

RECORDS CODE SHEET  
SND 4535 (Rev. 7/63)

NAVAL AVIATION SAFETY CENTER

GENERAL (Card No. 1)

SUPPLEMENTARY (Card No. 2)

Bureau Number	1 4 8 3 9 1	16-21	Weather	1				16-21
Reporting Custodian	1 5 6	22-24	Kind of Flight	3 A	3			22-24
Type Duty	J	25	Relative Wind + Direction	C				25
Major Command	I	26	Relative Wind + Velocity	I				26
Aircraft Damage	B	27	Special Attention	I				27
Aircraft Injury	G	28	-Clearance	2				28
Time of Day	4	29	Maneuver prior to Occurrence	7				29
Carrier Hull Number		30	Number of other Aircraft	I				30
First Accident type	A 2	31-32	Primary Causal Factor	F	3			31-32
First Accident phase	5 3 3	33-35	Altitude of Occurrence or Emergency					33-35
Second Accident type		36-37						
Second Accident phase		38-40						
Type of Operation	3	41-42						
Contributing Cause Factors	2 1 7 3	43-47	Non-Navy Injury ("R")					42
Pilot Factor, First	F 3	48-49	Number of "A" or "U" Injury					43-44
Pilot Factor, Second	W 2	50-51	Number of "B" Injury					46-47
Pilot Factor, Third	K 6	52-53	Number of "C" Injury					48-49
First other Personnel Factor	B 2	54-55	Number of "D" Injury					50-51
Second other Personnel Factor	E 1	56-57	Number of "E" Injury					52-53
Primary Major Material Factor		58	Number of "F" Injury					54-55
Secondary Major Material Factor		59	Number of "G" Injury	Q	4			56-57
Design		60	Location	A I M I R M P				62-68
Facilities		61						
Special Data & Cond.	M	62-65						
Special Data & Cond./Type of Incident		66						
Primary Cause	I	67						
1st Posit. of Pri. Causal Factor	F	68	ACCIDENT DAMAGE	G	3 0 8	1 2 1 0 2		
1st Possible Cause & Causal Factor		69-71		9	1 2 3	4 5 6		
2nd Possible Cause & Causal Factor		72-74	ACCIDENT INJURY	G	10			
No Personnel Card ("R")		80				- F 4 0		
			FISCAL YEAR	H	75	1 1 2 3 4 5		
						Model		
							Model Code	1 3
								75-77

PERSONNEL STATISTICS  
(Card No. 3)

File Number → (b) (6)

Name 16 17 18 19 20 21

03 (b) (6) 21 K A A 1 G 1 1 1 2 3 3 8 0 5 4 4 0 5 4 3 0 9 9 9

22 23 24 25 26 27 28 29 30 31 32 33 37 40 42 45 47 49 51 52-53 55 56-57 58-59 60-63 65-68 69 68-70 71-72 73-74

04 Name 16 17 18 19 20 21

File Number →

IBM: PERSONNEL CODED ON REVERSE SIDE

CODED *for* REVIEWED *for* LOGGED *for* PUNCHED *for* VERIFIED *for*

CODE SHEET REVIEWED BY CLASS DESK ANALYST *for* (initials) *for* (Date)

RECORDS CODE SHEET  
SND 4535 (Rev. 7/63)

NAVAL AVIATION SAFETY CENTER

GENERAL (Card No. 1)

SUPPLEMENTARY (Card No. 2)

Bureau Number	1 5 0 6 4 5	16-21	Weather	1			16-21
Reporting Custodian	1 6 2	22-24	Kind of Flight	3 A E			22-24
Type Duty	J	25	Relative Wind - Direction	S			25
Major Command	I	26	Relative Wind - Velocity	I			26
Aircraft Damage	B	27	Special Attention	I			27
Aircraft Injury	G	28	Clearance	2			28
Time of Day	Y	29	Maneuver prior to Occurrence	R			29
Carrier Hull Number		30	Number of other Aircraft	I			30
First Accident type	A 2	31-32	Primary Causal Factor				31-32
First Accident phase	5 3	33-35	Altitude of Occurrence or Emergency				33-35
Second Accident type		36-37					
Second Accident phase		38-40					
Type of Operation	not GCA at time	3	41-42				
Contributing Cause Factors	2 1 7	43-47	Non-Navy injury ("R")				42
Pilot Factor, First to Fault + flashing	0 5	48-49	Number of "A" or "U" Injury				43-44
Pilot Factor, Second	R 2	50-51	Number of "B" Injury				46-47
Pilot Factor, Third	S 0	52-53	Number of "C" Injury				48-49
First other Personnel Factor	B 2	54-55	Number of "D" Injury				50-51
Second other Personnel Factor	E 1	56-57	Number of "E" Injury				52-53
Primary Major Material Factor		58	Number of "F" Injury				54-55
Secondary Major Material Factor		59	Number of "G" Injury				56-57
Design		60	Location	A 1 M I R M P			62-68
Facilities		61					
Special Data & Cond.	M	62-65					
Special Data & Cond./Type of Incident		66					
Primary Cause		67					
1st Posit. of Pri. Causal Factor		68					
1st Possible Cause & Causal Factor	4 5	69-71	ACCIDENT DAMAGE	A	Own's Count	Enemy Action	Other Aircraft
2nd Possible Cause & Causal Factor		72-74	L D.	3 0 8	1 2 1 0 2		R
No Personnel Card ("R")		80	NO <sub>s</sub>	1 2 3	4 5 6 7 8	DAY TYP SEQ	

ACCIDENT INJURY	4	10	- F 4 C
FISCAL YEAR	4	75	11 12 13 14 15 Model

Model Code 9 0 78-77

PERSONNEL STATISTICS  
(Card No. 3)

File Number → (b) (6)

Name 16 17 18 19 20 21

(b) (6)

	Rank/Rate	Bir Service	Age	Yrs Experience	Status	Position	In to Ind	Abandon A/C	Pilot Trainer	Trainer Utilization	Instr. Card	Total Time All Models	All Models 3 Months	All Series This Model	All Ser Used 3 Months	CV Leadings	Instrument Hours	Line Hours	Total Time Jet Models
00	5 1 5 2 A 1 1 G 1 1	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	9 9 2 0 6 0 4	
01	2 2 2 3 2 4 2 5 2 6 2 7 2 8 2 9 2 0 2 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1	3 2 3 3 3 7 4 0 4 2 4 5 4 7 4 9 5 1

Name 16 17 18 19 20 21

File Number →

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CODED  REVIEWED  LOGGED  PUNCHED  VERIFIED

CODE SHEET REVIEWED BY CLASS DESK ANALYST  (Initials)

149/103 (Date)

## A &amp; R DEPARTMENT NARRATIVE CODE SHEET

YEAR 1	MONTH 2	DAY 3	TYPE 4	NUMBER 5	DAMAGE 6	INJURY 7	MODEL 8	10	11	12	13	14	15	
3	0	8	1	2	1	8	2	8	G	-	F	4	B	

16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

BUREAU NUMBER

148391

7	5	7	6
7	7	7	9
4	1	3	6

7	9	8
0	2	0

## NARRATIVE BRIEF

16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70

391 F4 150645 STRUCK FRM REAR DUR LNDG ROLLOUT AT NIGHT BY F4 148391. 5C FT CLD LAYER MOVD OVER FLD. A/C FM LP LEFT R/W DIR TO LND. F4 150645 ENTD RD PTTRN W/LITES DIM & STEADY. F4 148391 HAD BEEN IN FULD PTTRN & MADE APPR TO RIGHT R/W LANDNG 35C-AM FT BEHIND 150645 WHICH WAS SLOWNG FOR EARLY TURNOFF. COL OCCURD ABT 6260 FT FM APPR END OF R/W. REC IN EXTREMIS W/PPTS DISRECHDONG TWR INST. LACK OF ADA AIRBASE CONTRDL & DISCIPLINE & ADHERENCE TO SOP.

7980  
2 1  
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PREPARED BY

JSDM

PUNCHED

K06 NOV 1963

VERIFIED

L

## COMPLETION SHEET

Action on Correction to	Action Required	Completed Code/Date
3750 - 1		/
DIR		/
Misc. Items for Action or Correction		
To Code	From Code/Date	
/		/
/		/
/		/
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	no close-out required Ruea	

Endorsements Reviewed and Action Completed on All Phases of this Report.

3500  
Ser 80/8983

30 OCT 1963

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66, OPNAVINST P3750.6E

SEVENTH ENDORSEMENT on FITRON 114 ser 1-63A/FITRON 96 ser 4-63A AAR  
concerning F-4B BUENO 148391/150645, accident occurring 12 August 1963,  
pilots [redacted]

From: Commander Naval Air Force, U.S. Pacific Fleet  
To: Commander, U.S. Naval Aviation Safety Center

Subj: FITRON 114 AAR ser 1-63A/FITRON 96 AAR ser 4-63A

1. Forwarded, concurring in the comments and recommendations of the Aircraft Accident Board and in the remarks contained in subsequent endorsements, as modified by the sixth endorser.
2. For purposes of safety awards this accident is administratively charged to FITRON 114.

(b) (6)  
[redacted]

By direction

Copy to:

BUWEPS (F 123)

COMNAVAVNSAPECEN (2 copies)

COMFAIRSDIEGO

CO NAS MIRAMAR

COMCARAIRGRU 9, 11

BUWEPSFLTREADREPPAC

BUWEPSREP ST. LOUIS

NAVY LIAISON OFFICER DIRECTORATE OF AEROSPACE SAFETY, USAF, MORTON AFB

CO FITRON 96, 114

COMMANDER FLEET AIR DETACHMENT, MIRAMAR

FF7/3750  
Ser: 80/ 2660

23 OCT 1963

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66, OPNAVINST 3750.6E

SIXTH ENDORSEMENT on VF-114 ser 1-63A/VF-96 ser 4-63A concerning F4B  
BUNO 148391 accident occurring 12 Aug 1963, pilots [redacted] (b) (6)

From: Commander Fleet Air San Diego  
To: Commander, U. S. Naval Aviation Safety Center  
Via: Commander Naval Air Force, U. S. Pacific Fleet  
Subj: VF-114 ser 1-63A/VF-96 ser 4-63A Aircraft Accident Report;  
forwarding of

1. Forwarded, concurring in the conclusions and recommendations of the Aircraft Accident Board, as modified by the remarks contained in subsequent endorsements, except as follows:

a. Concur with the third, fourth and fifth endorsers that the primary cause of this accident was a lack of prudent action by the pilot of Linfield 406. Failure to maintain positive visual contact with the aircraft ahead led to this accident.

b. Strongly concur with the second recommendation of the board. By copy of this endorsement CFAD Miramar is directed to ensure that future occurrences of this nature are eliminated.

c. Concur with the third recommendation of the board. Numerous Navy and Marine Air Stations operate F4 aircraft with runway lengths comparable to 24L at Miramar. The use of the left runway for final landings out of MLP when 24R is not available may cause user squadrons the inconvenience of increasing turn around times and efforts. However, the inconvenience and dollar expenditures caused by this and future similar accidents is not acceptable.

d. Concur with the board concerning a 6000' night landing interval. Exceptions, as noted by the fifth endorser, are bound to occur, but they should be exceptions and the pilot should be sufficiently warned of the situation. This step or a similar one, is mandatory until the limited night visibility of the F4 is corrected.

e. Concur with the boards' seventh recommendation as modified by paragraph 4c of the fifth endorsement.

FF7/3750

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66, OPNAVINST 3750.6E

Subj: VF-114 ser 1-63A/VF-96 ser 4-63A Aircraft Accident Report;  
forwarding of

f. Concur with the third, fourth, and fifth endorsers that a right hand traffic pattern to 24R would increase traffic problems.

g. Do not concur with first and second endorsers' recommended revisions of weather minimums. The established weather minimums are adequate. These minimums should be strictly adhered to, and pilot information concerning local conditions that may affect Miramar should be promptly relayed to the Operations Duty Officer.

h. Concur with fourth and fifth endorsers concerning the use of field glasses.

i. Concur with recommendations included in paragraph 5 of the third endorsement.

*E. P. Rankin*  
E. P. RANKIN  
CHIEF OF STAFF

Copy to:  
BUWEPS (F 123)  
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CO, NAS MIRAMAR  
COMCVG-9  
COMCVG-11  
BWFRPAC  
BUWEPSREP ST LOUIS  
NAVY LIAISON OFFICER DIRECTORATE OF  
AEROSPACE SAFETY, USAF, NORTON AFB  
CO, VF-114  
CO, VF-96  
CPAD MIRAMAR

ORIGINAL

O2.1  
Ser 1189  
8 October 1963

FIFTH ENDORSEMENT on VF-114 ser 1-63A/VF-96 4-63A of 12 Aug 1963 concerning  
P-4B BUNOs 148391/150645, pilots [REDACTED] (b) (6)

From: Commanding Officer, U. S. Naval Air Station, MIRAMAR  
To: Commander, Naval Aviation Safety Center  
Via: (1) Commander Fleet Air, San Diego  
(2) Commander Naval Air Force, U. S. Pacific Fleet

Subj: VF-114 ser 1-63A/VF-96 4-63A Aircraft Accident Report; comments  
concerning

1. Forwarded.

2. The cause factors as postulated in paragraph three of the Fourth Endorsement are generally concurred with. However the basic cause of this accident is considered to be the failure of the pilot of Lindfield 406 to establish an adequate landing interval on Showtime 602; to keep Showtime 602 in sight throughout the approach and landing; and to effect a wave-off vice landing when he lost sight of Showtime 602. All other factors discussed in the basic report and endorsements are valid as contributing factors but as pointed out in the Fourth Endorsement cannot be considered as being direct causes. One factor not assessed by the Board as a contributing factor, which should be, was the failure of the LSO to land the MLP aircraft on 24L as ordered by the tower and the LSO's verbose and argumentative radio transmissions which grossly impeded air traffic control procedures.

3. The tower controller did err in that he failed to observe and advise the pilot of Showtime 602 of his improper illumination and in allowing Lindfield 406 to land before Showtime 602 had rolled past the 6000' marker. Reindoctrination of tower controllers has been accomplished to enhance compliance with existing instructions. However it should be noted that the establishment of a 6000' landing interval is somewhat arbitrary and derogates operating efficiency when compared with the practice of letting pilots select their own landing interval. This restriction was imposed as the result of a previous night overrun accident in an effort to prevent just such an accident as this. Due to human errors, attempts to rigidly enforce this or any greater interval will probably not completely eliminate such accidents and at times may work against the flexibility required to permit landings at reduced interval to effect expeditious recoveries in the interest of safety due to deteriorating weather, numerous low state aircraft in the pattern or some other combination of unusual circumstances. It is probable that the only positive means of preventing accidents of this type is conformance with paragraph 422.1 of Air Traffic Control Procedures (AT P7110.1A) which requires that "the preceding aircraft has taxied off the runway before the succeeding aircraft crosses the approach end thereof on its final glide". However in accordance with military

Subj: VF-114 ser 1-63A/VF-96 4-63A Aircraft Accident Report; comments concerning

necessity under paragraph 421.2 of AT P7110.1A the determination of a landing interval of undefined reduced separation has traditionally been the prerogative of individual pilots as monitored by tower controllers. If tower personnel are considered culpable in accidents of this nature additional clarification of the juxtaposition of military necessity and complete safety is required.

4. The following comments are considered pertinent:

a. Runway 24L (an 8000' runway) is adequate for final landings, day or night. Pilots must be prepared and mentally conditioned to make final landings on 24L after MLP if ordered by LSO or the tower. However traffic permitting final landings on 24R will be the normal procedure. The lengthening of runway 24L to 12,000' would of course enhance safety and pilot comfort.

b. Present regulations require pilots to roll to the end of the runway unless cleared by the tower to turn off at the 8,000 or 10,000 exits on 24R.

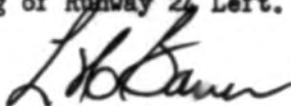
c. The procedure proposed in recommendation seven by the AAR Board is basically sound and the practice which has been and is followed by most pilots. However this Command interposes no objection to aircraft being landed slightly off center as proposed in paragraph 1.b. of the First Endorsement and paragraph 4.a. of the Fourth Endorsement provided that the aircraft are of the same flight, prebriefed, and maintain visual contact with the aircraft ahead during the rollout. It must be remembered by all concerned, however, that tower personnel at night cannot visually determine an aircraft's lateral position on the runway.

d. The recommendation that a right hand pattern be established for runway 24R is not concurred with. Simultaneous operation of right and left hand patterns would make visual contact with all VFR traffic virtually impossible for tower personnel. There would also be an unacceptable conflict with radar traffic on final approach.

5. The recommendations that MLP be eliminated, that NAF El Centro be used for MLP, that MLP weather minima be revised and that radio discipline be enforced are all considered valid but not germane to this accident. All these recommendations have a central point in reduction of traffic at NAS MIRAMAR. The calendar year 1962 produced over 238,000 operations at NAS MIRAMAR. From 1 January 1963 through 30 September 1963 a count of over 235,000 operations have been recorded. These figures establish a noticeable increase in traffic. The closing of Brown Field and traffic problems at NAS North Island have resulted in an increasing demand for the use of runways at MIRAMAR for MLP and touch and go landings.

Subj: VF-114 ser 1-63A/VF-96 4-63A Aircraft Accident Report; comments concerning

6. The lengthening of Runway 24 Left to 12,000 feet would reduce the demand on Runway 24 Right and thereby enhance the safety of operations. The Chief of Naval Operations five-year Military Construction Plan FY 64-68 dated 15 March 1962 included a project for the extension of Runway 24 Left. However, the latest Military Construction Components EPP FY 64 dated 15 May 1963 does not contain a project for the lengthening of Runway 24 Left.

  
L. H. BAUER

## Copy to:

NAVAVNSAFECEN (2)

BUWEPS

COMNAVAIRPAC

BUWEPSREP ~~St. Louis~~ St. Louis

COMCARAIRGRU NINE

COMCARAIRGRU ELEVEN

NFSLI, Norton AFB

CO FITRON 96

CO FITRON 114

**ORIGINAL**

PP12/CVG9/JBN:br  
3750  
Ser: 377  
26 September 1963

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST 3750.6E

FOURTH ENDORSEMENT on VF-114 ser 1-63A/VF-96 4-63A of 12 AUG 1963  
concerning F4B BuNo 148391/150645, pilots (b) (6)

From: Commander Carrier Air Group NINE  
To: Commander Naval Aviation Safety Center  
Via: (1) Commanding Officer, U. S. Naval Air Station, Miramar, California  
      (2) Commander Fleet Air, San Diego  
      (3) Commander Naval Air Force, U. S. Pacific Fleet  
Subj: VF-114 ser 1-63A/VF-96 4-63A Aircraft Accident Report

1. Forwarded.
2. The aircraft accident board, in its effort to ensure complete coverage of all the circumstances that may have been a contributing factor, has included a considerable amount of detailed information on airfield conditions, weather, traffic, etc., for the period preceding the accident. In analyzing the information gathered it is necessary to sort out the matter germane to this accident and remove that which tends to cloud the picture. It is essential to determine, in the sequence of events leading up to this accident, just where the accident itself began; i.e., just at which point was an accident likely to occur. Comments in this endorsement will be restricted to this area.
3. The failure on the part of the pilot of Showtime 602 to have his aircraft lights on bright and flash; the failure of tower personnel to ensure that the aircraft lights were on bright and flash and that there was sufficient interval between aircraft; the numerous radio transmissions; and the deteriorating weather conditions all, in retrospect, may have had a bearing on this accident. However, none of these conditions singularly or in combination could be considered a direct cause of this accident. The facts indicate that shortly before the landing of Linfield 406, the pilot of Linfield 406 did see Showtime 602 ahead of him in the pattern and did take interval on him as substantiated in enclosure (14). Up to this moment, though conditions were far from ideal, there was no reason to assume an accident was inevitable or even probable. Shortly thereafter, however, the pilot of Linfield 406, as stated in enclosure (14), lost sight of the aircraft ahead of him. His decision to continue his approach and landing behind an aircraft he no longer saw led to this accident. The additional speed at touch down coupled with the delay in deploying the drogue chute rapidly closed the close landing interval resulting in an overtake of Showtime 602. Showtime 602 had slowed to "turnoff speed" at approximately 6000 feet down the runway which, according to the accident board was the result of excessive braking. Inasmuch as the personal experience of this

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAV INST 3750.6E

**ORIGINAL**

PP12/CVG9/JBH;br  
26 September 1963

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST 3750.6E

endorser does not substantiate this conclusion, an attempt was made, subsequent to this accident, to duplicate the landing conditions of Showtime 602. Identical aircraft configuration, including fuel quantity, was used in a landing at NAS Miramar in calm wind conditions, on speed, and on the mirror. Without any braking action, except that provided by the drogue chute, the aircraft decelerated to well below normal taxi speed within the first 6000 feet of the runway. The ground speed at impact, estimated at 100 knots, at the 6260 foot point on the runway indicates that Linfield 406 may have landed faster and/or longer than estimated.

4. The conclusions of the AAR board are not concurred in for the reasons stated above.

a. The recommendations of the AAR board are concurred in except number seven. Landing in the center of the runway at night is considered good airmanship and adequate landing interval should be maintained to permit this. Any steadfast rules requiring turns right or left on roll out should not be necessary. Exceptions should be made for aircraft in the same flight to land on alternate sides of the runway where the aircraft separation is ensured by prebriefed landing procedures.

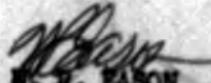
b. The recommendations contained in the endorsements to this accident report are concurred in with the following exceptions:

(1) 8000 feet of roll out is considered adequate to safely stop an F4B in a light-weight condition.

(2) A right hand traffic pattern for 24R at Miramar would add to the problem of aircraft traffic control when two runways are being used.

c. The recommendations contained in paragraph 5 of the third endorsement are strongly concurred in. An exterior master light switch located on the throttle, with a three position switch, FLASH - OFF - STEADY, is recommended for all single piloted aircraft.

5. It is recommended that all pilots receive periodic briefs concerning the danger of losing sight of the aircraft ahead and the importance of initiating proper action to determine the whereabouts of that aircraft. The use of the time honored wave-off, when in doubt, is the safest course of action.

  
W.R. EASON

Copy to:

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BUWEPS      BUWEPS REP STL NPSLI, MORTON AFB  
COMNAVAIRPAC      CC NAS MIRAMAR CO FITRON 96

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST 3750.6E

ORIGINAL

VP-96:10:shmc  
3750  
Ser 489  
17 SEP 1963

THIRD ENDORSEMENT on VF-114 ser 1-63A/VP-96 4-63A of 12 AUG 1963 concerning  
F4B BUNO 148391, pilots (b) (6)

From: Commanding Officer, Fighter Squadron NINETY-SIX  
To: Commander Naval Aviation Safety Center  
Via: (1) Commander Carrier Air Group NINE  
     (2) Commanding Officer, U.S. Naval Air Station, Miramar, California  
     (3) Commander Fleet Air San Diego  
     (4) Commander Naval Air Force, U.S. Pacific Fleet

Subj: VF-114 ser 1-63A/VP-96 4-63A Aircraft Accident Report

1. Forwarded, concurring with the recommendations of the Aircraft Accident Board as modified by the subsequent endorsements except for paragraph 1.a. of the first endorsement, paragraph 6.b. of the second endorsement; and not concurring with the conclusions of the Aircraft Accident Board for the following reasons:

a. It is considered that the primary cause of this accident was a human failing on the part of CDR (b) (6). The contributing cause factors include misleading radio transmissions from LTJG (b) (6) enclosure (18) at 2131 "602 turn-off at 10"; and by the tower controller WOODS, M. T., AC2, enclosure (18) at 2131 "602 continue rollout F-4 closing on left side". These transmissions contributed to CDR (b) (6) continuing light breaking and rolling straight ahead vice emergency action until he visually sighted the F4B ahead. Additional contributing factors include a breakdown of radio discipline, air traffic control procedures, adverse weather conditions — and aircraft design.

b. LTJG (b) (6) failure to turn his lights to BRIGHT/FLASH is not considered a deficiency in pilot briefing or technique. It is more probable that his normal habit pattern was broken due to his concern for maintaining safe visual separation from the numerous aircraft in both the ILS and normal traffic patterns under the prevailing low visibility conditions. In addition, the position and the relatively complex switch arrangement of the exterior lighting panel of the F4B is not conducive to ease of manipulation on the part of the pilot without possible undue preoccupation. This is particularly dangerous while flying at low altitude during night or bad weather operations. However, LTJG (b) (6) had ample opportunity to switch his lights to BRIGHT/FLASH after separating from his wingman. His failure to do so may have contributed to an already hazardous situation. It is also considered doubtful if CDR (b) (6) would have seen the aircraft ahead of him on the runway even if the lights had been on BRIGHT/FLASH. The drag chute of the F4 tends to block out the white tail light completely when viewed

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAV INST 3750.6E

ORIGINAL

from astern. The position of the anti-collision light on the forward edge of the vertical fin precludes the sighting of this light astern without careful and close scrutiny. Therefore, aircraft design is considered a contributing cause factor in this accident.

c. The wording of LTJG (b) (6) statement (enclosure (9)) indicates that he mistook the 6000 foot turn-off for the 10,000 foot turn-off. When interviewed, he stated this was not true and that he made no attempt whatever to turn off at the 6000 foot taxiway. In addition, it is considered that his deceleration was normal for a 31,500 lb. gross weight 128 knot landing with normal drag chute actuation and deployment upon touch down. The fact that both aircraft landed on the same side of the runway; the first decelerating normally, while the second had a delay in drag chute deployment coupled with a higher landing speed and closer than normal separation; is considered the primary cause factor.

2. It is virtually impossible for tower personnel to visually ascertain with any degree of accuracy if an aircraft is on the left, center or right side of the runway at night due to the lack of depth preception. The night landing interval must be maintained in the order of 6000 feet to preclude accidents of this type. When less interval is accepted due to emergency situations the tower must be able to control traffic separation by close radio control. A timely radio call to ascertain LTJG (b) (6) position with respect to the centerline would probably have prevented his accident. Unfortunately, the tower frequency was completely jammed with unnecessary transmissions (enclosure (18)) at a crucial time.

3. Paragraph 1.a. of the first endorsement is not concurred in. The use of 24 left for emergency situations only would increase the present congestion and further tax the capabilities of all concerned. In addition, any average F4 pilot should be able to land safely on an 8000 foot runway even if the drag chute fails.

4. It is recommended that:

a. The traffic pattern remain unchanged. If the tower personnel are required to maintain visual contact with all VFR traffic, simultaneous right and left hand patterns would probably result in additional traffic hazards. If both the NLF pattern (500 feet) and the normal traffic pattern (1500 feet) are adhered to by all pilots, then safe lateral and vertical separation would be maintained.

b. When an aircraft accident occurs, the occupants of the aircraft concerned be examined immediately by the flight surgeon called to the scene. This was not done in the case of LTJG (b) (6) and LCDR (b) (6)

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAV INST 3750.6E

5. In view of the fact that aircraft design is considered a contributing cause factor it is also recommended that:

a. The F4 lighting be modified to include a 360° (anti-collision) Grimes light to be visible from all aspects.

b. The exterior master light switch be modified to include a three position switch FLASH-OFF-STEADY in place of the spring loaded momentary On-OFF-ON switch on the left throttle.

6. LTJG (b) (6) is a well qualified first tour pilot. He has just completed one WestPac deployment and has no previous accidents. On page I-IV-4 LTJG (b) (6) night hours for the last three months should be 0.4 vice 4. He has had five night landings at NAS Miramar during July and August and a total of 44.4 night hours since deploying on 9 November 1962.

7. Aircraft Accident Prevention Survey completed 15 June 1963.

*William P. Mulholland*  
WILLIAM P. MULHOLLAND

DIST to:

CC: 2  
LSC (2)  
NAVAIRPAC  
COMFAIRSDIEGO  
DJWEPREP STL  
NAS MIRAMAR  
CVG-9  
NFSLI, NORTON AFB  
FITRON 114

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF CH-NAV INST 3750.6E

SP12/CVG-11/00:pf  
3750/4  
Ser: 188  
6 September 1963

# ORIGINAL

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST 3750.6E

SECOND ENDORSEMENT on VF-114 ser 1-63/VP-96 4-63 of 12 August 1963  
concerning F4B BUNO's 148391/150645, pilots (b) (6)

From: Commander Carrier Air Group ELEVEN  
To: Commander Naval Aviation Safety Center  
Via: (1) Commanding Officer, Fighter Squadron NINETY-SIX  
(2) Commander Carrier Air Group NINE  
(3) Commanding Officer, U.S. Naval Air Station, Miramar  
(4) Commander Fleet Air San Diego  
(5) Commander Naval Air Force, U. S. Pacific Fleet

Subj: VF-114 ser 1-63A/VP-96 4-63A Aircraft Accident Report

1. Forwarded, concurring with the recommendations of the Aircraft Accident Board as modified by the first endorser.
2. NAS Miramar is often exposed to heavy traffic loading of high performance aircraft during marginal VFR to IFR weather conditions. At night, there exists hazardous conditions even though the weather is clear. The confusion of lights in the area and the heavy jet traffic severely taxes the capabilities of the tower crew, and the pilots in the pattern.
3. There is a heavy night commitment for all VF aircraft operating out of Miramar. This tends to provide peak loads during the usable hours of darkness prior to the roll-in of the low clouds from the sea. The natural aggressiveness of the aviators and the desire of the field operations personnel to keep flying unrestricted as much as possible assists the development of dangerous situations. It is possible to have the field VFR by regulation but not VFR when the volume of aircraft and the speed of the aircraft is taken into consideration. In addition, because of the peculiar weather developments, it is possible to have parts of the traffic pattern VFR and other parts IFR.
4. As a marginal situation develops the area can suddenly become overloaded by aircraft from GCA practice, normal VFR traffic, MLP aircraft low state for final landing, and BINGO aircraft low state from carriers at sea. This traffic is hard to handle efficiently and the confusion factor increases as radio contacts are made and pilots become oriented to traffic conditions. An example of this is apparent in enclosure (18) of this AAR.
5. An additional danger factor during marginal weather conditions is the mirror landing system. Pilots are trained to fly mostly by instruments and to concentrate on a good mirror pass. This tends to distract them from a thorough look out doctrine as they near the final approach phase. The MLP pattern and the normal landing pattern can over-lap the GCA pattern.

# ORIGINAL

JF12/CVG-11/00:pf  
Ser: 188  
6 September 1963

6. The following recommendations are offered to prevent further accidents of this type and to lessen the possibility of a mid-air collision:

- a. Take immediate action to lengthen runway 24 Left so that both runways can be used without special braking procedures.
- b. Establish a right hand pattern for runway 24 Right and a left hand pattern for runway 24 Left.
- c. Invest money, manpower, and material in NAF El Centro and re-establish heavy MLP at El Centro.
- d. Raise the VFR restrictions at NAS Miramar to account for a high density of fast moving aircraft.
- e. Insist that tower personnel use field glasses if necessary to keep track of aircraft in the pattern and on the runway.
- f. Remind all pilots that tower instructions are mandatory and not a matter of discussion. (Excepting emergencies)
- g. Renew the emphasis on strict radio discipline.

*W H O'Neil*  
W. H. O'NEIL

Copy to:  
BUWEPS  
NASC (2)  
COMNAVAIRPAC  
COMFAIRSDIEGO  
BUWEPSREP STL  
NAS MIRAMAR  
CVG-9  
NFSLI, NORTON AFB  
FITRON 114

ORIGINAL

FFL2/VF-114  
3750/JJKett  
Ser: 757  
4 September 1963

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST 3750.6E

FIRST ENDORSEMENT on VF-114 ser 1-63A/VF-96 4-63A of 12 August 1963 concerning  
F4B BUNO's 148391/150645 pilots (b) (6)

From: Commanding Officer, Fighter Squadron ONE HUNDRED FOURTEEN  
To: Commander Naval Aviation Safety Center  
Via: (1) Commander Carrier Air Group ELEVEN  
     (2) Commanding Officer, Fighter Squadron NINETEEN  
     (3) Commander Carrier Air Group NINE  
     (4) Commanding Officer, U. S. Naval Air Station, Miramar  
     (5) Commander Fleet Air San Diego  
     (6) Commander Naval Air Force, U. S. Pacific Fleet

Subj: VF-114 ser 1-63A/VF-96 4-63A..

1. Readdressed, due to geographic separation from chain of command and forwarded, concurring with the recommendations of the Aircraft Accident Board with the following exceptions:

a. Runway 24 left is only 8000 feet long. Due to prevalent light and variable winds at Miramar during hours of darkness, together with possible drag chute failure, recommendation number four is not considered feasible. A slightly long and fast touchdown with coincident drag chute failure would tax the ability of the average pilot to stop before reaching the end of an 8000 foot runway. Landings under LSO control on 24 left should be reserved for an emergency situation only and then at the discretion of the tower supervisor.

b. Runway 24 right at NAS Miramar has centerline lighting. These lights are somewhat dimmer in intensity than the regular runway boundary lights but are easily discernable at night. In effect, the centerline lights create two parallel runways of 100 foot width each. This is a sufficient area to land any fighter aircraft now based at Miramar. Centerline landings would result in slowing down traffic with no appreciable increase in safety for the following reasons:

(1) It is extremely difficult to judge speed at night due to lack of reference to the ground. A turn to the right side of the runway at excessive speed could result in loss of control.

(2) Loss of parallel lineup with centerline and boundary lights while easing from center to right side of runway could cause the pilot to become disorientated in a maze of lights. The parallel light pattern must be maintained until slowed to turnoff speed.

(3) Aircraft with drag chutes, unless affected by strong crosswind factors, have a natural tendency to roll straight ahead upon landing. When slowed below 50-100 knots all rudder control is lost in the F4B and steering must be maintained by braking. Excessive braking for purposes of turning would result in a high incidence of tire wear and blown tires. When a crosswind does exist the pilot has his hands full to keep the aircraft rolling straight ahead rather than maneuvering on the runway.

2. Crowded traffic conditions at NAS Miramar have taxed the facilities provided for sometime. One of the most perplexing and dangerous situations is the conduct of MLP on 24 left while normal operations continue on 24 right. This situation creates two separate traffic patterns in addition to saturating the airport control zone with excessive numbers of aircraft. Even under ideal weather conditions the dual traffic pattern is difficult for tower personnel to control.

7  
ORIGINAL

Under adverse weather conditions such as existed at the time of the accident it becomes impossible for the tower to maintain absolute control over all aircraft.

a. Some possible solutions are:

- (1) Right hand traffic on 24 right.
- (2) Eliminate MLP at NAS Miramar.
- (3) Revise weather minimums upward for MLP.

It should be noted that the above discussion deals primarily with the traffic situation when the facilities are oversaturated rather than with specific procedures to be maintained such as landing interval and runway turnoff clearance procedures when the traffic can be controlled effectively.

b. This accident should never have happened. Although, the board was basically correct in including a breakdown of radio discipline, air traffic procedures and adverse weather phenomenon as contributing factors, it is still the responsibility of the pilot in actual control of the aircraft to exercise proper judgment. CDR (b) (6) exercised poor judgment in continuing his approach and landing after having lost sight of the aircraft ahead. LTJG (b) (6) used poor headwork in maintaining his lights on dim while in the traffic pattern. In addition, his apparent disorientation on the runway added to an already confused situation.

c. CDR (b) (6) is a well qualified, experienced aviator. He was involved in two previous accidents, one involving engine seizure in an F3B during a rainstorm and the other involved foreign object damage to an F3B during the takeoff run. Neither accident was attributed to pilot causes.

d. Aircraft Accident Prevention Survey completed 31 July 1963.

Copy to:  
BUWEPS  
COMNAVAVSAFECEN (2 copies)  
COMFAIRLSDIEGO  
COMNAVAIRPAC  
CVG-11  
CVG-9  
CO, VF-96  
BUWEPSREP, ST LOUIS  
DIRECTOR OF FLIGHT SAFETY, NAVY FLIGHT SAFETY LIAISON OFFICER, NORTON AFB  
CO, NAS Miramar

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PAR. 66 OPN.VINST 3750.6E

SECTION A - IDENTIFICATION	1. A/C ACCIDENT BOARD APPOINTED BY <b>Commanding Officer, Fighter Squadron 114</b>	2. DATE OF ACCIDENT <b>12 Aug 63</b>	3. TIME (LST) <b>2101LT</b>	4. 2. MODEL NUMBER <b>1-63A</b>			
	4	5. ENCLOSURES: (1) See Enclosure INDEX					
	TO: Commander Naval Aviation Safety Center	<input type="checkbox"/>					
	6. VM (1) CO, Fighter Squadron 114	<input type="checkbox"/>					
	7. CO, Fighter Squadron 96	<input type="checkbox"/>					
	8. Commander Carrier Air Group ELEVEN	<input type="checkbox"/>					
	9. Commander Carrier Air Group NINE	<input type="checkbox"/>					
	10. CO, U.S. Naval Air Station, Miramar	<input type="checkbox"/>					
	11. Commander Fleet Air San Diego	<input type="checkbox"/>					
	(7) Commander Naval Air Force, U. S. Pacific Fleet						
7. REPORTING CUSTODIAN (if different than item 1, above) <b>SAME</b>		8. ACTIVITY OPERATING A/C (if different than item 7.) <b>SAME</b>					
9. KIND OF FLIGHT <b>BA3</b>		10. TIME OF DAY <input type="checkbox"/> DAWN <input type="checkbox"/> DAY <input type="checkbox"/> DUSK <input checked="" type="checkbox"/> NIGHT	11. LOCATION OF ACCIDENT <b>Runway 24R NAS, Miramar</b>				
12. PLACE OF LAST TAKE-OFF <b>Miramar</b>		13. CLEARED: <b>FROM NAS Miramar TO NAS Miramar</b>					
14. TYPE CLEARANCE <input type="checkbox"/> IR <input checked="" type="checkbox"/> VFR <input type="checkbox"/> IFR <input type="checkbox"/> LOCAL <input type="checkbox"/> OPERATIONAL <input type="checkbox"/> AIRPORTS <input type="checkbox"/> DIRECT <input type="checkbox"/> OTHER							
15. TIME IN FLIGHT <b>0 / 46</b>		16. TYPE ACCIDENT <b>Collision, Aircraft on ground</b>		17. PHASE OF FLIGHT <b>Landing roll out</b>			
18. MODEL <b>F4B</b>		19. SERIAL NO. <b>148391</b>	20. DISTANCE TO A/C <input type="checkbox"/> A <input type="checkbox"/> B <input checked="" type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F	21. DURATION (hrs) <b>3635,000</b>			
				22. SPEED (KTS) <b>100 P</b>			
				23. A/C WEIGHT <b>32,000</b>			
24. LIST MODEL, SERIAL, REPORTING CUSTODIAN AND DOWNGE CLASSIFICATION OF ANY OTHER A/C INVOLVED (Complete on OPNAV FORM 3750-1 for each A/C involved)							
1. NAME (Last, first and middle initials) <b>(b) (6)</b>		2. GRADE <b>CIR</b>	3. RANK <b>USN</b>	4. AGE <b>39</b>			
		5. POSITION <b>Pilot</b>	6. BILLET <b>Front Cockpit</b>	7. PAY GRADE <b>G</b>			
CO-PILOT							
PERSONNEL		8. OFT - OPERATIONAL FLIGHT TRAINER <input type="checkbox"/> AVAILABLE <input checked="" type="checkbox"/> USED	9. CPT - COCKPIT PROC. TRAINER <input type="checkbox"/> AVAILABLE <input checked="" type="checkbox"/> USED	10. UNIT TO WHICH PERSONNEL ARE ATTACHED <b>Fighter Squadron 114</b>	11. TYPE INSTRUMENT CARD <input type="checkbox"/> STANDARD <input checked="" type="checkbox"/> SPECIAL		
PILOT		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> X <input type="checkbox"/> X				
CO-PILOT		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			<input type="checkbox"/> STANDARD <input type="checkbox"/> SPECIAL		
12. PERSONNEL DATA		ITEM	PILOT	CO-PILOT	ITEM	PILOT	CO-PILOT
		ALL MODELS	3886		CV LANDINGS DAY/NIGHT	285/34	
		ALL MODELS IN LAST 12 MONTHS	228		FCFL LANDINGS DAY/NIGHT	26/65	Last 12 mos.
		ALL MODELS IN LAST 3 MONTHS	58		INSTRUMENT HOURS LAST 3 MONTHS	3	
		A/C	447		NIGHT HOURS LAST 3 MONTHS	9	
THIS MODEL (Rev. M)		OFT / CPT	12/12		TOTAL HELD. HRS. (Rev. AAF Only)	---	
THIS MODEL LAST 12 MONTHS		A/C	224		TOTAL JET HOURS (Rev. AAF Only)	1990	
THIS MODEL LAST 3 MONTHS		OFT / CPT	8/1		LAST FLIGHT, ALL SERIES THIS MODEL	12 AUG 63	
		A/C	58		DATE	12 AUG 63	
		OFT / CPT	0/1		TIME	1 / 49	
13. NAME (Last, first and middle initials) <b>(b) (6)</b>		4. GRADE <b>NO LT</b>	5. GRADE <b>(b) (6)</b>	6. FILE/SERVICE NO. <b>VF-114</b>	7. UNITS TO WHICH ATTACHED <b>VF-114</b>	8. PAY GRADE <b>G</b>	9. PAY GRADE <b>110 AAF CO-CAPT</b>
1.							
2.							
3.							
4.							
5.							

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750.6C

## AIRCRAFT ACCIDENT REPORT

1. CARRIER 500 BKN	2. VISIBILITY 6	3. RELATIVE WIND GEE METR'D 305 KNOTS / 6 MTS	4. TEMPERATURE OAT 57°F WIND 40°F	5. ALTITUDE 64°F	6. ALTITUDE METERS 29,93
-----------------------	--------------------	--	---	---------------------	-----------------------------

7. OTHER WEATHER CONDITIONS (clouds above, icing levels, sun shots, etc. if pertinent to accident)

✓	FACTOR	✓	FACTOR	✓	FACTOR
X	PILOT		LANDING SIGNAL OFFICER		MATERIAL FAILURE OR MALFUNCTION
	CREW		OTHER PERSONNEL (Spots)		DESIGN
	SUPERVISORY PERSONNEL		ADMINISTRATIVE		ROLLING AND PITCHING DECK/ ROUGH SEAS
	MAINTENANCE PERSONNEL	X	AIRPORT OR CARRIER FACILITIES		UNDETERMINED
	SERVICING PERSONNEL	X	WEATHER		OTHER (Spots)

## FOR ACCIDENTS ABOARD DEPLOYED CARRIER (Complete following Section on File)

1. DATE DEPLOYED NA	2. DAY - HOURS/LANDINGS LOGGED SINCE DEPLOYED	3. DAY - HOURS/LANDINGS LOGGED LAST 30 DAYS
4. INSTRUMENT HRS. LOGGED SINCE DEPLOYMENT	5. NIGHT - HOURS/LANDINGS LOGGED SINCE DEPLOYED	6. NIGHT - HOURS/LANDINGS LOGGED LAST 30 DAYS

## PART II - MAINTENANCE, MATERIAL, AND FACILITIES DATA

ITEM	DATE OF MANUFACTURE	SERVICE TOUR	MONTHS IN THIS TOUR	TOTAL NO. OF OVERHAULS	FLIGHT HRS. SINCE LAST OVERHAUL	FLIGHT HRS. SINCE ACCEPTANCE	TYPE CHECK LAST PERFORMED	FLIGHT HOURS SINCE LAST CHECK	NO. OF DAYS SINCE LAST CHECK
1									
2									
3									
4									
4. DID FIRE OCCUR? <input type="checkbox"/> BEFORE ACCIDENT <input type="checkbox"/> AFTER ACCIDENT <input checked="" type="checkbox"/> DID NOT OCCUR							5. DID EXPLOSION OCCUR IN FLIGHT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
6. CHECK IF APPLICABLE <input type="checkbox"/> AMP FOR SERIAL				7. HAS DIE BEEN REQUESTED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		8. FAILED COMPONENTS INVOLVED: NONE			
CHECK ITEMS PRESENT IN THIS ACCIDENT									
a. <input type="checkbox"/> A/C DESIGN		d. <input type="checkbox"/> UNDETERMINED		e. <input type="checkbox"/> SURFACE FACILITIES					
b. <input type="checkbox"/> A/C EQUIPMENT		e. <input type="checkbox"/> TECHNICAL INSTRUCTION		f. <input type="checkbox"/> HUMAN ENGINEERING (e.g. Cockpit configuration, etc.)					
c. <input type="checkbox"/> MAINTENANCE		f. <input type="checkbox"/> OTHER (Spots)							
g. ALTITUDE AT MALFUNCTION		h. AIR SPEED		i. OPERATING TEMP.		j. WEIGHT OF A/C		k. C.G. (T.O. MAX)	
		Kts.		°F		LBS. OF FUEL		LBS. FUEL PRESSURE	
l. EVIDENCE OF FUEL CONTAMINATION									
m. CAUSE OF ENGINE FAILURE OR FLAMEOUT									
n. EXTERNAL STORES ARCHED AVG -C/L 600 GAL. DROP TANK									

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PAGE 35 OF OPNAVINST 3750.6B

## AIRCRAFT ACCIDENT REPORT

## PART II - MAINTENANCE, MATERIAL, AND FACILITIES DATA (CONT'D)

1. GENERAL - BASIC FACILITIES INVOLVED. DESCRIBE EFFECT ON ACCIDENT IN THE ANALYSIS SECTION OF THE REPORT

a. CLEARANCE AUTHORITY	b. WATER LANDING AREA	c. CRASH AND RESCUE
b. FLIGHT PLANNING INFORMATION SOURCE	d. APPROACH ZONE	e. SEARCH AND RESCUE
c. LANDING AIDS (GCA, CCA, ILS, etc.)	e. END ZONE (DWP AREA)	f. CATAPOULT
X d. TRAFFIC CONTROL TOWER (Field or Ship)	f. SHOULDER	g. ARRESTING GEAR (Carrier)
e. APPROACH AND ENROUTE AIDS TO NAVIGATION	g. TAXWAY	h. BARRIER OR BARRICADE (Field or Ship)
f. RUNWAY WATCH	h. PARKING AREA	i. FLIGHT DECK
g. LANDING SIGNAL OFFICER	i. EMERGENCY ARRESTING GEAR (Runway)	j. MIRROR
h. RUNWAY	j. A/C SERVICING, HANDLING AND DIRECTING (Field or Ship)	k. OTHER (Specify)

2. EQUIPMENT INVOLVED:  CATAPOULT       PRESSURE SETTINGS       WING OVER DECK       RELATIVE HEADING       APPROACH SPEED (SPW 12 SECONDS) ARRESTING GEAR       LOCATION ON SHIP       LAUNCHING BRIDGE AND CONFIGURATION USED

3. CATAPOULT / ARRESTING GEAR BULLETINS OR NOMOGRAMS USED

4. THIS PORTION SHALL BE COMPLETED WHENEVER (1) A MAJOR AIRCRAFT ACCIDENT INVOLVES ARRESTING GEAR, BARRIER AND/OR BARRICADE EQUIPMENT, OR (2) AN AIRCRAFT ACCIDENT INVOLVES MALFUNCTIONS OF ARRESTING GEAR, BARRIER AND/OR BARRICADE EQUIPMENT. MINOR ACCIDENTS OR ROUTINE DAMAGE TO CABLES, WELDINGS AND OTHER EXPIREABLE COMPONENTS NEED NOT BE REPORTED.

ENGAGED	DECK RUNOUT (FT)	RIM TRAVEL (IN)	CONTROL VALVE SETTINGS		ACCUMULATOR OR PRESSURE (PSI)	COMMENTS (For cable failures specify number of landings and minutes in service)
			CONSTANT PRESSURE DOME (PSI)	RATIO		
DECK PENDANT						
DECK PENDANT						
BARRIER						
BARRIER						
BARRICADE						

PART	SECTION	ITEM	PART III REMARKS (Comments on referenced items)	COPY DISTRIBUTION
IV			ADDITIONAL BOARD MEMBERS:  (b) (6)  (b) (6) LCDR, Safety Officer, VA-112  (b) (6)  LT, Safety Officer, VF-114	200. NAVFLEETPAC DIRECT NOV BUMPS (DIRECT) CONNAVAIRPAC (DIRECT) CO, VF-96 (Direct) COMPAIRSDIEGO (DIRECT) BUMPS REF STL (DIRECT) COMAS, MIRAMAR CONCAIRGRU ELEVEN CONCAIRGRU NINE NAVY FLIGHT SAFETY MAISON OFF, NORTON AFB DATE SUBMITTED TO C.G. 29 AUGUST 1963

COST DAMAGE TO:	GOVERNMENT PROPERTY	PRIVATE PROPERTY
S	NONE	NONE

PART IV - SIGNATURES ON THIS BOARD		
SENIOR MEMBER OF BOARDING Officer, VAH-13	MEMBER Operations Officer, VF-114	UNIT BILLET
W. P. CARLIN, Commander	Lieutenant Commander	UNIT BILLET
(b) (6)	(b) (6)	LT(C) CONCAIRGRU ELEVEN
(b) (6)	(b) (6)	LCIR

LT (b) (6) VF-96 Safety Officer was invited as a board member, but was unable to participate due to a CVG-11 MIDPAC deployment aboard USS KITTY HAWK (CVA-63).

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750.6B

## PART I - GENERAL

1. A/C ACCIDENT BOARD APPOINTED BY Commanding Officer, Fighter Squadron 114		2. DATE OF ACCIDENT 12 Aug 63	TIME ZLDT 2131T	3. SERIAL NUMBER 4-63A
4. TO: Commander Naval Aviation Safety Center		5. ENCLOSURES: (1) SEE ENCLURE INDEX		
6. VIA: (1) CO, Fighter Squadron 114		(2)		
(2) CO, Fighter Squadron 96		(3)		
(3) Commander Carrier Air Group ELEVEN		(4)		
(4) Commander Carrier Air Group NINE		(5)		
(5) CO, U.S. Naval Air Station, Miramar		(6)		
(6) Commander Fleet Air San Diego		(7)		
7. REPORTING COMMANDER (if different than item 1. above) Commanding Officer, Fighter Squadron 96		8. ACTIVITY OPERATING A/C IF different than item 7. SAME		
9. KIND OF FLIGHT 3A6		10. LOCATION OF ACCIDENT Runway 24L NAS, MIRAMAR		
11. TIME OF DAY □ DAWN □ DAY □ DUSK <input checked="" type="checkbox"/> NIGHT		12. ELEVATION ABOVE SEA LEVEL 477 FT		
13. PLACE OF LAST TAKE OFF NAS, MIRAMAR		14. CLEARED FROM NAS, MIR/MAR TO NAS, MIR/MAR		
15. TYPE CLEARANCE <input type="checkbox"/> IFR <input type="checkbox"/> VFR <input type="checkbox"/> PIREP <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> OPERATIONAL		<input type="checkbox"/> AIRWAYS <input type="checkbox"/> DIRECT <input type="checkbox"/> OTHER (Specify)		
16. TIME IN FLIGHT 1 4 38		17. PHASE OF FLIGHT Landing roll out		
18. TYPE ACCIDENT Collision, Aircraft on Ground		19. MODEL F4B		
20. SERIAL NO. 150645		21. DAMAGE TO A/C <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F		
22. DOLLAR COST \$635,000		23. AIRSPEED (KTS) 30 E		
24. A/C WEIGHT 31,500				
25. LIST MODEL, SEP NR, REPORTING CUSTODIAN AND DAMAGE CLASSIFICATION OF ANY OTHER A/C INVOLVED (Complete an OPNAV FORM 3750-1 for each A/C Involved)				

1. N° 46 (Last, first and middle initials)	2. RANK RATE	3. FILE NO.	4. DATE ISSUED	5. DATE EXPIRED	6. DATE LAST USED	7. DATE LAST FLYED	8. POSITION IN COCKPIT	9. BRIEF CODE
(b) (6)	LTJG	(b) (6)					FRONT Cockpit	G

PERSONNEL	8. OFT - OPERATIONAL FLIGHT TRAINER		9. CPT - COCKPIT PROC. TRAINER		10. UNIT TO WHICH PERSONNEL ARE ATTACHED	11. TYPE INSTRUMENT CARD	
	AVAILABLE	USED	AVAILABLE	USED			<input checked="" type="checkbox"/> STANDARD <input type="checkbox"/> SPECIAL
PILOT	YES <input type="checkbox"/>	X	X	X	Fighter Squadron 96	<input type="checkbox"/> STANDARD <input checked="" type="checkbox"/> SPECIAL	
CO-PILOT	YES <input type="checkbox"/>					<input type="checkbox"/> STANDARD <input checked="" type="checkbox"/> SPECIAL	
12. PILOT EXPERIENCE IN HOURS	ITEM	PILOT	CO-PILOT	ITEM		PILOT	CO-PILOT
ALL MODELS		667		CV LANDINGS DAY/NIGHT		78/34	
ALL MODELS IN LAST 12 MONTHS		211		FCLP LANDINGS DAY/NIGHT		215/103	
ALL MODELS IN LAST 3 MONTHS		46		INSTRUMENT HOURS LAST 3 MONTHS		5	
ALL SERIES THIS MODEL (Item 29)	A/C	355		NIGHT HOURS LAST 3 MONTHS		4	
ALL SERIES THIS MODEL LAST 12 MONTHS	A/C	211		TOTAL HELD HRS. (See AAR Only)		-	
ALL SERIES THIS MODEL LAST 3 MONTHS	A/C	46		TOTAL JET HOURS (See AAR Only)		614	
NAME (Last, first and middle initials)	DATE LAST FLYED	DURATION		LAST FLIGHT, ALL SERIES THIS MODEL		3/12/63	
1. (b) (6)							
2.							
3.							
4.							
5.							

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750.6C

## AIRCRAFT ACCIDENT REPORT

OPNAV REPORT AREA

1. CEILING 500 EKN	2. VISIBILITY 6	3. RELATIVE WIND (SEE INST'S) 305 deg / 4 KTS	4. TIME OF DAY 1400Z	5. DEW POINT 64 F	6. ALTIMETER SETTING 29.93
7. OTHER WEATHER CONDITIONS (winds shear, icing limits, sea state, etc.) (If applicable to 125-68-4)					

✓	FACTOR	✓	FACTOR		
X	PILOT	LANDING SIGNAL OFFICER	MATERIAL FAILURE OR MALFUNCTION		
	CREW	CIVILIAN PERSONNEL	DESIGN		
	SUPERVISORY PERSONNEL	ADMINISTRATIVE	ROLLING AND PITCHING DECK/ROUGH SEAS		
	MAINTENANCE PERSONNEL	AIRPORT OR CARRIER FACILITIES	UNDETERMINED		
	SERVICING PERSONNEL	WEATHER	OTHER (Specify)		
FOR ACCIDENTS ABOARD DEPLOYED CARRIER (Locate following section on Page)					
1. DAY - HOURS	2. DAY - HOURS/LANDINGS LOGGED SINCE DEPLOYED	3. DAY - 1. DLRG/LANDINGS LOGGED LAST 30 DAYS			
77A					
4. INSTRUMENTS NOT USED SINCE DEPLOYMENT	5. NIGHT - HOURS/LANDINGS LOGGED SINCE DEPLOYED	6. NIGHT - HOURS/LANDINGS LOGGED LAST 30 DAYS			

## PART II - MAINTENANCE, MATERIAL AND FACILITIES DATA

1. LOCATION	DATE OF MANUFACTURE	SERVICE TOUR	MONTHS IN THIS TOUR	TOTAL NO. OF OVERHAULS	FLIGHT HRS. SINCE LAST OVERHAUL	FLIGHT HRS. SINCE ACCEPTANCE	TYPE CHECK LAST PERFORMED	FLIGHT HOURS SINCE LAST CHECK	NO. OF DAYS SINCE LAST CHECK
	NOT APPLICABLE								
		EXCINE MODEL	ENGINE SERIAL NO.						
2. ENGINE HISTORY	1								
3									
4									
3. GENERAL	b. DID FIRE OCCUR?		d. AFTER ACCIDENT		c. DID NOT OCCUR		e. DID EXPLOSION OCCUR IN FLIGHT?		
	<input type="checkbox"/> BEFORE ACCIDENT	<input type="checkbox"/> AFTER ACCIDENT					<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	
	e. CHECK IF APPLICABLE		f. HAS DIR BEEN REQUESTED?		g. FAILED COMPONENTS INVOLVED				
	<input type="checkbox"/> AMP/FUS SERIAL		<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO		NONE			
CHECK ITEMS PRESENT IN THIS ACCIDENT									
4. HUMAN AND ENVIRONMENTAL FACTORS	b. <input type="checkbox"/> A/C DESIGN	d. <input type="checkbox"/> UNDETERMINED	e. <input type="checkbox"/> SURFACE FACILITIES	f. <input type="checkbox"/> HUMAN ENGINEERING (e.g., Cockpit configurations, etc.)					
	c. <input type="checkbox"/> A/C EQUIPMENT	e. <input type="checkbox"/> TECHNICAL INSTRUCTION							
	g. <input type="checkbox"/> MAINTENANCE	h. <input type="checkbox"/> OTHER (Specify) -----							
5. OTHER DATA	a. ALTITUDE AT MALFUNCTION	b. AIR SPEED	c. OPERATING TEMP.	d. WEIGHT OF A/C	e. C.G. (% MAC)	f. BURN OF FUEL	g. FUEL PRESSURE		
	ft.	Kts.							
	i. EVIDENCE OF FUEL CONTAMINATION		j. CAUSE OF ENGINE FAILURE OR FLAMMABILITY						
	k. FUEL CONTROL REGULATOR/CARBURETOR (List stock and no. revs., give other than stock or manufacturer)		l. EXTERNAL STORES/HARD A/C						
			NONE						

(If additional space is necessary, attach add'l page(s))

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750-6B

## AIRCRAFT ACCIDENT REPORT

## PART II - MAINTENANCE, MATERIAL AND FACILITIES DATA (CONT'D)

I. GENERAL - BASIC FACILITIES INVOLVED, BECAUSE EFFECT ON ACCIDENT IN THE ANALYSIS SECTION OF THIS REPORT			
a. CLEARANCE AUTHORITY	b. WATER LANDING AREA	c. CRASH AND RESCUE	
b. FLIGHT PLANNING INFORMATION SOURCE	d. APPROACH ZONE	e. SEARCH AND RESCUE	
c. LANDING AIDS (GCA, CCA, ILS, etc.)	e. END ZONE (Off or Ship)	f. CATAPOULT	
d. TRAFFIC CONTROL TOWER (Field or Ship)	f. SHOULDER	g. ARRESTING GEAR (Carrier)	
e. APPROACH AND ENROUTE AIDS TO NAVIGATION	g. TANWAY	h. BARRIER OR BARRICADE (Field or Ship)	
f. RUNWAY WATCH	h. PARKING AREA	i. FLIGHT DECK	
g. LANDING SIGNAL OFFICER	i. EMERGENCY ARRESTING GEAR (Runway)	j. MIRROR	
h. RUNWAY	j. A/C SERVICING, HANDLING AND DIRECTING (Field or Ship)	k. OTHER (Specify)	
k. EQUIPMENT INVOLVED:		<input type="checkbox"/> CATAPOULT	b. PRESSURE SETTINGS
		<input type="checkbox"/> ARRESTING GEAR	c. WIND OVER DECK
l. MARK NUMBER	m. MODEL NUMBER	n. LOCATION ON SHIP	o. RELATIVE HEADING
p. LAUNCHING BRIDGE AND CONFIGURATION USED			
q. APPROACH SPEED (OPR) 12 FEET			
r. CATAPOULT / ARRESTING GEAR BULLETINS OR NOMOGRAMS USED			

SECTION B - FACILITIES DATA

2. LINE DATA

ENGAGED	DECK RUNOUT (FT.)	BIM TRAVEL (IN.)	CONTROL VALVE SETTINGS		ACCURAT- ION PRESSURE (OPR)	COMMENTS (for cable failure specify number of loadings and months in service)
			CONSTANT PRESSURE			
			DOME (P.S.I.)	RATIO		
DECK PENDANT						
DECK PENDANT						
BARRIER						
BARRIER						
BARRICADE						

PART	SECTION	ITEM	PART III REMARKS (Continue on additional sheets)	COPY DISTRIBUTION
IV			ADDITIONAL BOARD MEMBERS:  (b) (6)  [REDACTED] LCDR, Safety Officer, VA-112  [REDACTED] LT, Safety Officer, VP-114	JOC, NAVFIGHTER CARRIER DIRECT SOC BUMPS (DIRECT) CONNAVAIRPAC (Direct) CO, VF-96 (Direct) CONFAIRSDIEGO (Direct) BUMPS REF STL (Direct) CONAS, MIRAMAR CONCARAIRGRU ELEVEN CONCARAIRGRU NINE NAVY FLIGHT SAFETY MAISON OFF, NORTON AFB

LOSS DAMAGE TO:	GOVERNMENT PROPERTY	PRIVATE PROPERTY	DATE SUBMITTED TO C.O.
	S. NONE	NONE	29 AUGUST 1963

## PART IV - SIGNATURES OF THE BOARD

CHIEF OF STAFF, Executive Officer, VAH-13 CAGMAN, Commander	UNIT SAILOR (b) (6)	CHIEF OF STAFF, Executive Officer, VF-114 CAGMAN, Commander
(b) (6) (b) (6)	(b) (6)	UNIT SAILOR (b) (6)

LT (b) (6) VF-96 Safety Officer was invited as a board member, but was unable to participate due to a CVG-11 MIDPAC deployment aboard USS KITTY HAWK (CVA-63).

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750.6E

PART V - THE ACCIDENT

1. The accident occurred at NAS Miramar at 2131 12 August 1963. This field incorporates two parallel runways, the right runway (24R) 12,000 feet long, and the left runway (24L), 8,000 feet long. A left hand traffic pattern is used on both runways with altitude differential providing aircraft separation. Prior to the accident the field had been operating under VFR conditions with MLP in progress on runway 24L and all other traffic being handled on 24R. At approximately 2118, a low cloud layer (500 feet) started moving across the field from the west causing tower personnel to lose sight of aircraft on the crosswind and downwind legs of the pattern. Action was taken to set the field IFR, and the LSO was directed to terminate MLP and land his aircraft on runway 24L.

2. At about 2124, LTJG [REDACTED] USN of VF-54, pilot of F4B BUNO 150645, MOLLY SHOWTIME 602, having returned from a routine night intercept flight was in the landing pattern for runway 24R. He had entered the pattern from a GCA wave-off with external lights on dim and steady and without benefit of the anti-collision light. On his first landing approach, LTJG [REDACTED] (b) (6) waved off because of a close interval and uncertainty in identifying other aircraft in the pattern ahead of him. He landed on the left side of the runway on his second approach. During roll out prior to reaching the 6000 foot turnoff point, he requested tower clearance for turn-off at the 10,000 foot taxiway. The tower directed him to continue roll-out and advised him of another aircraft closing from behind on his left side. Shortly thereafter, at 6260 feet from the approach end of the runway the overtaking aircraft, F4B BUNO 148391 struck LTJG [REDACTED] (b) (6) aircraft from behind. LTJG [REDACTED] (b) (6) aircraft skidded 150 feet and turned 210 degrees left before coming to rest on the runway. F4B BUNO 150645 received BRAVO damage. Pilot and RIO, LCDR [REDACTED] (b) (6) USNR were uninjured.

3. CDR [REDACTED] (b) (6) USN, of VF-114, pilot of F4B BUNO 148391. MOBLEY LINFLLD 406, was in the FMLP pattern on runway 24L when the tower terminated MLP. Upon receipt of the tower's instruction to terminate MLP CDR [REDACTED] (b) (6) shifted to tower frequency, turned down wind and requested landing on 24R. He received landing instructions from the tower for 24R and acknowledged sighting his landing interval, SHOWTIME 602, ahead of him. While on the base leg, the tower asked him if he could make his landing on 24L, to which, he replied negative. The tower then cleared him for landing on 24R number two behind SHOWTIME 602. At this point he lost sight of the aircraft in front of him, however, believing that he had seen it land on the right side of the runway he continued his approach and landed on the left side. Having heard the other pilot call for turn-off at 10,000 feet and the tower advise of him closing on the left, he continued normal roll-out. He first saw the aircraft in front of him at 6060 feet. CDR [REDACTED] (b) (6) aircraft, F4B BUNO 148391 received BRAVO damage. Pilot and RIO, LT [REDACTED] (b) (6) USNR were uninjured.

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OPNAVINST P3750.6B

V-1

L-1

PART VI - DAMAGE TO AIRCRAFT

1. SHOWTIME 602, BUNO 150645, was struck from the right rear by LINFIELD 406, BUNO 148391. About 200 feet prior to impact, the pilot of LINFIELD 406 attempted to avoid collision by turning to the right and going around 602. Initial contact was made by the left outer wing panel of LINFIELD 406 when it struck the left stabilator of SHOWTIME 602 and continued beneath the tail section, raking the tail hook assembly, hook-to-keel junction and both afterburners, enclosure (1A). The starboard stabilator tip of SHOWTIME 602 contacted the port side of LINFIELD 406 just above the wing butt at mid chord, ripping a tear back to the port engine cavity door, enclosure (1B). As 406 continued to pass to starboard, the nose section contacted the starboard outer wing and flap assembly of SHOWTIME 602, enclosure (1C). 406 sustained a horizontal tear from its radome to the port outer duct line, impaling a section of 602's leading edge flap, enclosure (1D). Internal inspection of the tail section of SHOWTIME 602 revealed rupture of stress plates and fractured stabilator attach points, necessitating Overhaul and Repair rework, enclosure (1E). Divergence occurred as 150645 spun to the left about  $216^{\circ}$  and 148391 continued down the runway, finally pivoting to the right about  $120^{\circ}$  degrees. Both aircraft remained on the runway.

2. A general description of damage to F4B BUNO 148391 follows:

A. Left fuselage horizontal tear from radome and F.S. 46.68 through forward variable ramp.

(1) Left side of radome raked.

(2) Angle of attack probe and surrounding plate demolished. Former rings located fore and aft of AA probe are fractured.

(3) Door 4L and 6L fractured.

(4) Estimated 50 percent CNI package destroyed.

(5) Fixed ramp severe damage.

(6) Forward variable ramp not repairable.

(7) Radar package minor damage.

B. Left engine overhaul due to metal ingestion.

C. Left engine inlet duct raked F.S. 203.0 through F.S. 245.06.

(1) Inner duct skin ruptured from lip through F.S. 230.40.

(2) Outer duct skin ruptured from lip through F.S. 245.06.

(3) Panel 125L demolished.

(4) Duct formers F.S. 209.85 through F.S. 223.55 estimated repairable by O & R.

D. Left wing leading edge flaps.

(1) Center flaps outboard half repairable by O & R.

(2) Outboard flap destroyed.

(3) Outboard wing panel estimated total loss.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750.6B

- E. Left fuselage ruptured about F.S. 414.
- (1) Door 47L and fuselage ruptured through to engine cavity.
  - (2) Fuselage tear F.S. 426 through F. S. 453.30.
  - (3) Trailing edge flaps hard point and adjacent fairing destroyed.
3. A general description of damage to F4B BUNO 150645 follows:
- A. After fuselage area damage from stabilator to aft right engine door.
- (1) Left and right aluminum honeycomb section of stabilator ripped.
  - (2) Stabilator actuator damaged and stabilator attachment fittings (fuselage mounted fractured); stress plate between attach fittings ripped.
  - (3) Clevis tie down fitting damaged.
  - (4) Arresting gear fairing destroyed and arresting gear shank damaged.
  - (5) Variable nozzles damaged on both afterburner duct assemblies.
  - (6) Engine access door (96R) torn.
  - (7) Arresting gear dampers damaged.
- B. Starboard wing damage.
- (1) Right fuel dump mast destroyed.
  - (2) Right aileron damaged.
  - (3) Outboard right wing panel estimated total loss.
  - (4) Outboard leading edge flaps estimated total loss.

4. BUNO 148391 was transferred to AMD NAS Miramar 15 August 1963 for transportation to North Island NAS O & R Bravo damage repair. BUNO 150645 is awaiting transportation to North Island NAS for O & R damage repair.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750.6E

PART VII - THE INVESTIGATION AND ANALYSIS

1. The Investigation

a. General. The investigation commenced immediately upon occurrence of the accident and the following sources of information were investigated:

(1) Witnesses. Statements were obtained from the crew members of both aircraft involved, the LSO and control tower personnel on duty at the time of the accident.

(2) Logs and Records. Pilot flight logs and training records of CDR (b) (6) were examined and pertinent information extracted. Records of LTJG (b) (6) were not available to the board. However, appropriate extract and summary of flight experience were provided by his ISIC. Aircraft maintenance records and logs were not considered pertinent to the accident and therefore were not used in the investigation.

(3) Tape Recording. The magnetic tape recording of voice communications between Miramar tower and airborne traffic were studied and analyzed to verify sequence of events, corroborate statements of witnesses and to determine information and factors pertinent to the accident.

(4) Instructions and Directives. Pertinent CPNAV, NATOPS, COMNAVAIRPAC, NAS MIRAMAR, and VF-114 instructions were reviewed for determination of compliance or non-compliance with flight regulations and operating procedure.

(5) Photographs. Photographs of aircraft skid marks were studied and used to determine distances, extent of aircraft damage, and pilot actions.

b. Detailed Account. The following information and matters pertinent to the accident were uncovered in the course of the investigation.

(1) A resume of CDR (b) (6) flying experience is set forth in enclosure (2).

(2) A resume of LTJG (b) (6) flying experience is set forth in enclosure (3). He had flown 4 hours at night in the preceeding 3 months prior to this accident.

(3) Both pilots were on authorized training flights. CDR (b) (6) was scheduled by VF-114 for a routine night FMFLP flight for a scheduled duration of approximately 0.8 hours, enclosure (4). LTJG (b) (6) was scheduled by VF-96 as a section wingman for a routine night intercept flight for a scheduled duration of 1.7 hours, enclosure (5).

(4) No sociological, psychological, or physiological factors which could be related to the accident were disclosed in the Medical Officer's Report on either pilot, enclosures (6) and (7), (original only).

(5) CDR (b) (6) was admitted to Balboa Hospital on 22 July 1963 for (b) (6). He was released from the hospital on 9 August 1963, examined and cleared for flight by a flight surgeon on 12 August 1963.

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

(6) CDR (b) (6) had flown a refresher flight of 1.8 hours duration on the day of the accident. He had flown .8 hours on the flight in which the accident occurred.

(7) CDR (b) (6) post accident medical examination showed no physical deficiency or fatigue factors which could be related to the accident.

(8) The NAS Miramar complex consists of two parallel runways approximately 500 feet apart. The right runway (24 RIGHT) is 12,000 feet long and 200 feet wide. The left runway (24 LEFT) is 8,000 feet long and 200 feet wide, enclosure (8). Both runways utilize a left hand traffic pattern. Pattern altitude for 24R is 2000 feet MSL and PMLP pattern altitude for 24L is 1000 feet MSL. Field elevation is 477 feet MSL.

(9) Shortly before the accident, a 500 foot (AGL) scattered to broken layer of clouds moved in over the western boundary of the field, restricting visibility and making it difficult for tower personnel to identify and keep aircraft in the VFR landing pattern under visual surveillance.

(10) During the course of his flight, LTJG (b) (6) assumed the lead of the two plane section, and properly set his external lights on dim and steady for formation flying. (b) (6)

(11) At approximately 2116, LTJG (b) (6) and wingman returned to NAS Miramar by means of a section TACAN and GCA approach. On completion of the approach, the flight was broken up and both pilots proceeded independently. LTJG (b) (6) entered the GIA box pattern and, on separation from his wingman, failed to reset his external lights to bright and flashing, enclosures (9) and (10).

(12) At approximately 2119, tower personnel notified the Operations Duty Officer of the deteriorating weather condition and were instructed to terminate the PMLP when they considered it necessary, enclosure (11).

(13) At approximately 2120, CDR (b) (6) was cleared to enter the PMLP pattern on 24L from a GCA wave-off to a low approach. However, because of the heavy traffic and restricted visibility existing in the immediate vicinity of the field, he effected a VFR reentry into the PMLP pattern.

(14) At approximately 2124, LTJG (b) (6) terminated his second GCA to a low approach and joined the NAS Miramar VFR traffic pattern for final landing on runway 24R.

(15) At 2126, the tower terminated PMLP and instructed the LSO to land all PMLP aircraft on 24L.

(16) From 2126 - 2128, five radio transmissions were required from the tower before the LSO took action to terminate PMLP.

(17) At 2126, LTJG (b) (6) took a wave off from his first approach to a final landing on 24R because of the close interval held on an unidentified aircraft ahead of him. He climbed above the cloud layer and remained in the VFR landing pattern for 24R. Following his wave-off, LTJG (b) (6) was lost from the tower's sight and was not identified again until approaching the 180 position for runway 24R at 2128, enclosure (12).

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 66 OF  
OPNAVINST P3750.6E

(18) At 2127, upon interception of the tower's transmission to the LSO to terminate FMLP, CDR (b) (6) shifted from LSO to tower frequency and turned down wind from an FMLP touch and go landing for a final landing on 24R.

(19) At 2128, immediately following CDR (b) (6) shift to tower frequency, the tower twice repeated, in emphasis, its instruction to the LSO to land his aircraft on runway 24L.

(20) At 2128, CDR (b) (6) was advised by the tower that his interval, LTJG (b) (6) aircraft, was approaching the 180 position for 24R, enclosure (13). He acknowledged having his interval in sight and continued his approach, enclosures (14) and (15).

(21) At 2129, the tower cleared LTJG (b) (6) to land. Tower personnel were not certain of the aircraft's position in the pattern as evidenced by their mistake in identifying LTJG (b) (6) aircraft as another aircraft, "Old Nick" 116, which was already on deck.

(22) At 2129, while CDR (b) (6) was turning on base leg to 24R, the tower instructed him to set his approach to 24L. This instruction was changed to an inquiry as to his capability of setting his approach to 24L after he responded passing the 90 degree position. To the tower's inquiry, CDR (b) (6) replied in the negative and was then cleared to land on runway 24R, number 2, behind LTJG (b) (6) airplane.

(23) At 2130, LTJG (b) (6) as a result of an angling approach, landed on the left side of the runway.

(24) CDR (b) (6) lost sight of the aircraft ahead of him during the latter part of his approach. However, believing that he had seen the aircraft land on the right side of the runway at a safe interval ahead of him, he continued his approach and also landed on the left side of the runway.

(25) It was estimated that the landing distance between aircraft was 3500 - 4000 feet.

(26) CDR (b) (6) touchdown speed was approximately 7 - 10 knots greater than LTJG (b) (6) and his deceleration was considerably less because of delayed drag chute actuation.

(27) LTJG (b) (6) mistook the 6000 foot runway turn-off for the 10,000 foot turn-off. He requested tower clearance for turn-off at 10,000 feet before reaching the 6000 foot turn-off point. The tower denied his request for turn-off, directed him to keep his aircraft rolling and warned him of an aircraft overtaking him on his left side. The tower's warning was transmitted with approximately 1500-1800 feet separation between aircraft.

(28) The tower cautioned CDR (b) (6) of another F4B aircraft rolling out 1000 feet ahead. CDR (b) (6) was unable to discern the aircraft ahead.

(29) At approximately 200 feet from SHOWTIME 602, as evidenced by the skid marks of the overtaking aircraft, enclosure (15), CDR (b) (6) made out the silhouette of the aircraft in front of him and attempted to avoid collision by turning right with use of rudder brake and nose-wheel steering.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 66 OF OPNAVINST P3750.6B

(30) Collision occurred at 2131T, 6260 feet from the approach end of the runway. LTJG (b) (6) aircraft, F4B BUNO 150645, skidded forward approximately 150 feet and spun left about 210 degrees before coming to a stop on the runway. CDR (b) (6) aircraft, F4B, BUNO 148391, veered to the right, and skidded in a sinuous manner approximately 420 feet while executing a 120° turn to the right before stopping on the runway.

(31) Both aircraft were shut down and evacuated.

(32) The field was set IFR at 2131, enclosure (17).

(33) NAS Miramar's Air Operations Manual was reviewed and the following information found applicable to this accident.

(a) Page 30, para 3-5h. "Jet aircraft will roll to the 8000 foot turn-off prior to departing either parallel runway (Runway 24L/R)."

(b) Page 30, para 3-5i. "Night touch and go with simultaneous night MLP is authorized (not encouraged) and approval must be requested from tower. Ceiling and visibility are determining factors as well as the number of aircraft night flying. Touch and go aircraft on 24R must climb to 1500 feet before turning left. (Be alert to avoid MLP aircraft)."

(c) Page 32, para 3-7g. "In order for pilots and the tower personnel to recognize aircraft at night, incoming pilots will turn aircraft lights to bright and flashing at the time they enter the break, all lights on aircraft in the Mirror Landing Practice pattern will be bright and steady."

(34) ALNAV 142 (COMM VAIRPAC MSG 032216Z of October 1962) is applicable and is quoted in part.

(a) "Good operating procedure indicates that at night, if overcast is high enough, pilots should turn running lights to bright and flashing either upon breaking clear or during landing roll-out after aircraft is well under control. Pilots of aircraft equipped with Grimes Anti-collision lights should also turn on Grimes light at above time provided control switch location permits operation without unsafe pilot pre-occupation."

(35) Commanding Officer, NAS Miramar FOURTH ENDORSEMENT on VF-141 ALR 3-62/VF-143 ALR 1-62 on a similar type accident. "The following remedial action was initiated among others at NAS Miramar."

(a) "The landing interval has been increased during night operations. This action derogates operational capability but is necessary to insure that a similar accident does not occur."

(b) "In compliance with ALNAV AIRFA 142 each pilot will be expected to turn "on" the Grimes anti-collision light before or shortly after touchdown. If an aircraft on the runway fails to show a Grimes Light passing the 6000 foot marker, subsequent aircraft will not be allowed to land until preceding aircraft either shows a Grimes Light or clears the runway."

#### (36) NATOPS

(a) NATOPS requirements or procedures were not violated.

(b) The NATOPS Manual was being complied with.

(c) With the exception of night MLP, no mention is made in the NATOPS Manual of external lighting procedures.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST P3750.6A

2. THE ANALYSIS

a. Personnel.

Although at first glance this accident would appear to be a simple case of one pilot over-running another aircraft on the runway, analysis of all factors uncovered in the investigation indicates a compounding of human errors and numerous direct and indirect contributing factors. Therefore, for reasons of simplicity, the analysis of personnel factors related to the accident are divided into separate areas of responsibility including CDR (b) (6) pilot of F4B BUNO 148391, the overtaking aircraft; LTJG (b) (6) pilot of F4B 150645, the overtaken aircraft and, Control Tower personnel controlling the aircraft at the time of the accident.

(1) Pilot Factors. CDR (b) (6) was considered to be physically and mentally prepared for the flight and had ample time between flights for adequate food and rest. His three week lay-off from flying, by reason of hospitalization, is not considered excessive nor an uncommonly long period for a pilot to be away from flight, and therefore is not considered a factor in this accident. The flight surgeon's examination both prior to and after the accident disclosed no adverse psychological or physiological factors which could be related to the accident, inclusive of the effects of the illness for which he had previously undergone medical observation. Until the time that he had returned to Miramar at 2120, his flight had been normal in all respects. On reaching Miramar for the purpose of joining the MLP pattern, he chose to use the secondary method of entry (elliptic reentry) because of the high density of traffic and reduced visibility in the area. He received the tower's instruction to terminate MLP while he was making his first MLP approach and, after take off, he shifted to the tower frequency for the purpose of making a final landing on runway 24R. This action which is in general practice at NAS Miramar under normal conditions, was proper, however, under the prevailing circumstances was a mistake which contributed to the cause of the accident. At this time, the cloud layer over the field lay between the MLP traffic pattern altitude and the VFR pattern altitude.

Because of the clouds, the tower was unable to keep the aircraft in the VFR pattern in sight and therefore, in an effort to maintain separation of the conflicting traffic patterns, had directed the 180 to land MLP aircraft on runway 24L. After turning downwind, he picked up his interval, LTJG (b) (6) aircraft, at what he termed "approaching the 90 degree position" as he left the 180 degree starting position. LTJG (b) (6) was making an angling approach from a wide 180 degree starting position. Thus his 90 degree position would be considerably wider abeam than normal. Assuming that CDR

(b) (6) approach pattern was normal and the fact that his gross weight required a higher approach speed, the already short landing interval between the aircraft was considerably reduced in the turn. As the aircraft ahead approached the ground and presented a more tail-on aspect to CDR (b) (6), its dimly lit external lighting was lost in the back drop of multicolored field lighting. Having been forewarned by the tower's repeated efforts to have him land on runway 24L, he should have initiated a wave-off at this point or at the very least have planned for a wave-off in case he was unable to resight the aircraft ahead prior to touchdown. Instead, thinking that he had seen the aircraft ahead land on the right side of the runway, he chose to effect separation by landing on the opposite side of the runway. During roll-out, he was lulled into a false sense of security by LTJG (b) (6)'s request for turn-off at 10,000 feet and then by the tower's advice to the aircraft ahead that he was closing from behind on the left side. Warning by the tower that he had an aircraft 1000 feet ahead proved to no avail since the inadequate lights of the F4B ahead were further masked by the deployed drag chute. Thus, the aircraft was not visible until too late to avoid collision.

(2) LTJG (b) (6) had taken over the lead of his two plane section because of radio difficulties which had been experienced by his wingman. In accordance with standard formation doctrine, he had properly set his external lights on dim and steady. However, upon separating from his wingman on return to the field, he forgot to reset his lights to bright and flashing as required by local regulation and good airmanship. Without his lights on bright and flashing, his anti-collision light was not operating, a peculiarity of the F4B airplane. LTJG (b) (6) made three approaches and a final landing on runway 24L with his aircraft in this condition. During his final approach, not only was CDR (b) (6) unable to keep him in sight, but as evidenced by several inquiries for his position, tower personnel were not able to keep him in sight either. As the number one aircraft cleared to land, LTJG (b) (6) aircraft was the privileged aircraft. However, such privilege is predicated on the premise that the aircraft is operated in a normal and predictable manner. In this case, LTJG (b) (6) mistake in identifying the 6,000 foot turn-off as the 10,000 foot turn-off caused him to effect premature and excessive braking action resulting in abnormally rapid deceleration. The fact that LTJG (b) (6) attempted to turn-off the runway prior to reaching the 8,000 foot point as required by NAS Miramar Instructions is not considered a violation of course rules, but a matter of disorientation on the part of the pilot. His action in decelerating his aircraft rapidly in addition to inadequate aircraft lighting must therefore be considered a contributing factor to the accident.

b. Facilities

(1) The Control Tower personnel controlling aircraft at the time of the accident were highly experienced, duly qualified Air Controlmen familiar with NAS Miramar air traffic regulations and procedures. Prior to the time of the accident, heavy traffic existed in the area with MLP in progress on runway 24L and all other traffic including GCA approaches, final landings, and touch and go landings being handled on 24R. Aircraft were converging on the field and joining the landing pattern from many different directions including two separate VFR entry points, GCA wave-offs, finals from MLP, and entries to MLP. Primary tower frequencies were close to saturation. At approximately 2118, a bank of clouds moved in across the western boundary of the field obscuring aircraft on the crosswind and downwind legs of the 2,000 foot VFR pattern and thus complicating an already difficult air traffic control problem. At 2119 the tower supervisor, upon advising the CDO of the deteriorating weather, was advised to terminate MLP as the situation warranted. This action was not taken until 2126. During the interim, CDR (b) (6) had been cleared to enter the FMLP pattern at 2120, and LTJG (b) (6) completed his second GCA approach at 2124. The tower continued to experience extreme difficulty in keeping track of and positioning aircraft in the pattern. The tower's decision both to terminate MLP and land MLP aircraft on 24L was sound, however, under the existing circumstances, considered to be somewhat late. Pressure on the tower had already been built up and was further aggravated by its inability to obtain positive and timely action from the LSO in landing his aircraft on runway 24L. In addition, generally poor radio discipline in the area also acted to derogate the tower's control effectiveness. These conditions undoubtedly influenced the tower's decision to allow CDR (b) (6) to set up his approach to 24R in lieu of directing him to land on 24L or effect a reentry. The tower's repeated request for CDR (b) (6) to land on 24L during his approach is indicative of either apprehension or uncertainty of the safety aspects of his approach and therefore, should have been followed up by go-around instructions. The tower also erred in allowing him to land before the aircraft on the deck had reached the 6,000 foot point without anti-collision light operating as required by local doctrine. In addition, tower personnel allowed LTJG (b) (6) to operate in the pattern for three separate approaches without informing him of the inadequate lighting condition of his aircraft.

c. NATOPS

(1) This accident indicates a need for a revision to the F4B NATOPS Flight Manual with regard to aircraft lighting procedures. A recommendation has been proposed in accordance with OPNAVINST 3750.9.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST 3750.9E

PART VIII - CONCLUSIONS

1. It was established that the primary cause of this accident was a human failing on the part of both pilots. Contributing cause factors included a breakdown of radio discipline, air traffic procedures and adverse weather phenomenon.

2. Pilot Factors.

a. CDR (b) (6) should have complied with repeated tower instructions for MLP aircraft to land on runway 24L.

b. A landing interval was established and accepted by CDR (b) (6) which was too close on the aircraft ahead for night final landings.

c. CDR (b) (6) showed poor judgment in continuing his approach to a landing instead of waving-off after losing sight of the aircraft ahead.

d. Misleading transmissions from LTJG (b) (6) and the tower, to the effect that the aircraft being overtaken was a considerable distance farther down the runway ("10,000 feet"), and located on the right ("aircraft closing from the left"), afforded CDR (b) (6) a false sense of security which derogated the tower's warning of the aircraft ahead of him.

e. LTJG (b) (6) created a hazardous situation for all aircraft in the Miramar traffic pattern when he failed to turn his lights to BRIGHT/FLASH after he separated from his wingman. This is considered a deficiency by the pilot either in flight briefing or technique. Illumination of the F4 aircraft with aircraft lights on DIM/STEADY is negligible when viewed from the rear with the drag chute deployed.

f. LTJG (b) (6) mistake in identifying the 6,000 foot turn-off for the 10,000 foot turn-off caused him to effect premature braking and deceleration which compounded the hazard of his inadequately lit aircraft. His disorientation on the runway is attributed to unfamiliarization with the field lighting presentation due to the limited number of recent night flights from N.A.S. Miramar.

3. Facilities.

a. The tower supervisor and the controlling operator erred when they cleared CDR (b) (6) to land behind LTJG (b) (6). They were fully aware of the close approach interval between the two aircraft, which obviously was closer than the required 6,000 foot roll-out interval stipulated by station policy for night landings.

b. The tower should have noted the improper lighting of LTJG (b) (6) aircraft and advised him of the fact. He made one visible approach and wave-off past the tower prior to his final landing preceding the accident.

c. The LSO failed to comply with the tower's instructions for him to terminate MLP by landing MLP aircraft on runway 24L. Unfortunately, he hindered the landing operation by questioning the tower's decision to terminate MLP due to the low clouds which had been reported below field MLP minimums.

4. The prevailing low clouds along the Southern California coast contributed to this accident. Since the prevailing wind is from the west, aircraft in the upwind end of the traffic pattern were forced above the clouds to remain VFR and are thus lost from the tower's vision.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST 3750.6E

5. Standard Operating Procedures.

a. MLP aircraft generally make their final landings on runway 24R, the longer of the two runways. Pilots are therefore reluctant to make final landings on runway 24L, particularly during a weather recall. Pilots of aircraft in the MLP pattern failed to comply with the towers instruction to make final landings on runway 24L, since all aircraft landed either with or without tower clearance on runway 24R.

b. Aircraft are presently permitted and practically required to make staggered landings on alternate sides of the runway. At night, there is no positive way for tower personnel to know on which side of the runway an aircraft has landed. Pilots must have the aircraft ahead in sight to know which side of the runway to plan their approach. Since this accident occurred due to uncertainty of one pilot as to which side of the runway the aircraft ahead had landed on, staggered landings at night are questionable as safe practices.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPN.VINST 3750.6E

PART IX - RECOMMENDATIONS

1. Practices of good airmanship must be continually emphasized to all pilots of every experience level.
2. Tower tapes should be reviewed frequently by operations personnel for breaches of radio discipline and non-compliance with tower instructions. Offenders should be singled out and cited through proper channels.
3. MLP aircraft at N.A.S. Miramar should make final landings under LSO control on runway 24 LEFT when MLP is terminated by the tower. This would lessen traffic congestion and curtail communication clutter on the tower primary frequency.
4. Pilots should insure a night landing interval of at least 6,000 feet between aircraft on the runway. (Section landing excepted). Tower personnel should wave off aircraft if this interval is not established.
5. Jet aircraft should roll to the end of the runway for final night landings at N.A.S. Miramar unless specifically cleared earlier by the tower. Pilots will not initiate requests to turn off the runway.
6. Tower personnel should share the responsibility for insuring that aircraft accepted under their control at night comply with external lighting requirements. Aircraft with improper lighting should be advised to check their lights.
7. Miramar course rules be modified to include the following standardized night landing and roll-out procedure. "All final night landings shall be made in the center of the runway. Roll-out on runways 24R/L will be held in the center of the runway until the aircraft has slowed to a comfortable speed. The aircraft should then be eased to the right side of the runway and roll-out continued on the right until turn-off is effected. Upon tower caution of a dangerous overtaking situation or when such a situation becomes apparent to the pilot, the pilot of the overtaking aircraft shall take the left side of the runway and the pilot of the aircraft being overtaken shall doubly insure his positioning on the right."

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST 3750.6B

STATEMENT OF (b) (6) CDR, USN, (b) (6) PILOT OF F4B BUNO 14839  
CONCERNING VF-114 SER 1-63A/VF-96 SER 4-63A OF 12 AUG 1963: PILOTS (b) (6)  
(b) (6)

On the evening of 12 August 1963 I launched for a scheduled night FMLP flight. After 30 minutes of flight I made a TACAN approach to a low approach and was cleared by the tower to enter the downwind leg for FMLP. Due to restricted visibility and excessive traffic I made a Elliot reentry and was cleared by the LSO to enter downwind for FMLP. On the final portion of my first MLP the tower requested the LSO to land all aircraft due to restricted visibility. After becoming airborne from the MLP, I switched to tower frequency and was cleared for downwind entry for final landing. The tower cautioned of a SHOWTIME aircraft ahead, Showtime 602, was approaching the 90 degree position as I left the 180 degree position. Due to other radio traffic I was unable to call the 180 degree report until approaching the 90 degree position. The tower asked if I could land 24L but I felt committed to 24R and was cleared to land 24R. At this time I lost the lights of the aircraft ahead. Turning into the final I saw what I thought was SHOWTIME 602 landing on the right side at a safe interval. I continued my approach to the left side of runway 24R, picking up a low meat ball. My touchdown was on speed on the indexer (about 135kts) at about 3200 # fuel weight. I placed the throttle in idle and actuated the drag chute handle. The handle did not operate on the first pull so I pulled again with proper results. When I was passing (approx) the 8000' marker SHOWTIME 602 called for turnoff, so although I still could not distinguish his lights I felt a good interval was being maintained. The tower denied his request and directed that he continue roll out. The tower cautioned me of aircraft ahead but I still could not make out his lights. At this time I commenced light braking. Shortly after, I began to see the silhouette of SHOWTIME 602 directly ahead, but the lights could not be seen. I immediately hit right brake and commenced a right swerve and alerted the RIO with a "Heads up" on the ICS. Just as I was attempting to increase the swerve with nose wheel steering I struck the right wing of SHOWTIME 602 causing him to groundloop violently to the left. As he turned I could see his lights, apparently on "dim" I estimate my overtake speed to have been about 50-70 knots and ground speed to have been about 100 knots. After the collision I went from the right swerve into a left swerve and stopped in a final right swerve. After securing engines and switches I evacuated the aircraft with my RIO. My aircraft stopped about 500' beyond SHOWTIME 602.

This accident could have been prevented had I confirmed that SHOWTIME 602 had landed on the right side as I believed. Since I could not see any aircraft lights on right or left side, I should have checked with tower/602 for a definite position.

I believe that a contributing cause is the poor visibility of F4B lights when viewed from directly astern (especially when on dim).

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST P3750.6E

Enclosure (14)

STATEMENT OF CDR (b) (6) [REDACTED] CONTINUED)

A possible contributing cause, certainly not detracting from my responsibility, may have been excessive deceleration by ST 602 early in the rollout for a 10,000' turn off.

I have been a naval aviator for 13 years and have 3885 flight hours of which 445 have been in the F4H.

(b) (6)  
[REDACTED]

Certified a true copy

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

Flight Resume of CDR [REDACTED] (b) (6)  
Pilot of F4B 148391

<u>Fiscal Year</u>	<u>Command Attached</u>	<u>Model Aircraft</u>	<u>Flight Hours</u>	<u>Carrier Landings Day/Night</u>	<u>Operational Proficiency</u>
1960	VF-121	F3B	280	18/0	Operational
		TF-9J	2		
		F-10	6		
1961	VF-121	F-10	226		Operational
		F3B	31		
		F4B	70		
1962	VF-121	TF-9J	15		Operational
		F-10	112		
		F4B	174	26/7	
1963	VF-121	F-10	14		Operational
	DEC 62	F4B	72	5/6	
	VF-114	F4B	163	26/10	Operational
1964	VF-114	F4B	12		Operational

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6B

Enclosure ( 2 )

Flight Resume of LTJC [REDACTED] (b) (6)  
Pilot of F4B BUNO 150645

<u>Fiscal Year</u>	<u>Command Attached</u>	<u>Model Aircraft</u>	<u>Flight Hours</u>	<u>Carrier Landings Day/Night</u>	<u>Operational Proficiency</u>
1961	VT-1	T-34	14		Training
	VT-7	T2J-1	43	4/0	Training
	VT-21	F9F-8T/8B	52	3/0	Training
	VT-23	F11F	24		Training
1962	VH-126	F9F-8T	13		Operational
	VF-121	F4B	50		Operational
	VF-96	F4B	126	12/1	Operational
1963	VF-96	F4B	195	59/33	Operational
1964	VF-96	F4B	33		Operational

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

Enclosure ( 3 )

FIGHTER SQUADRON ONE HUNDRED FOURTEEN  
 c/o Fleet Post Office  
 San Francisco, California

SDO: ENS SKUBI  
 TYPE A/C: F4B  
 CALL: LINFIELD

Monday, 12 August 1963

SUNRISE: 0610  
 SUNSET: 1938

SQD	APC	APC	EVT	EVT	CODE	PILOT/RIO	FUEL MODEX	ETD	ETE	TIME	REMARKS
1	31	T-6	CDR	(b) (6)			Full 404	2015	1.8	2.2	MLP 2130-22
						BTM/MATDEN					B7 COM
						(b) (6)	"	409	"	"	2.1 "
2	32	T-6	CDR	(b) (6)			"	401	"	"	2.3 B7 COM
						(b) (6)	"	407	"	"	2.4 "
3			CDR	(b) (6)			"	406	"	"	0.8 "
						(b) (6)	"	400	"	"	1.6 "
4			(b) (6)				"	404	0030	0.5	6000# MLP
						CDR (b) (6)	"	401	"	"	El Centro
5			(b) (6)				"	400	"	"	0.5 "
						CDR (b) (6)	"	404	"	"	0.6 Return from
6			(b) (6)				"	407	"	"	El Centro
							"	409	"	"	0.5 "
							"	400	"	"	0.6 "
						CDR (b) (6)	"	401	"	"	0.5 "
7			CDR	(b) (6)			"	408	"	"	1.8 MLP at 1600
8			(b) (6)				"	404	"	"	1.5 Test

NOTES: (1) AOM 1300

Sorties Sked/Flwn 12/1  
 Hours Sked/Flwn 15.4

As of 8 August 1963  
 Sorties Sked/Flwn 64/59  
 Hours Sked/Flwn 112.3/95.1

"I certify that each pilot will be briefed on weather, flight plan and other pertinent information, and possesses necessary maps and charts and holds a valid instrument rating".

SUBMITTED:

APPROVED:

(b) (6)

(b) (6)

Flight Officer

Operations Officer

DIST: NAS OPERATIONS (6) SDO (10) FAD MIRAMAR (1) LINE (2) SHOPS (ea)  
 BARRACKS (1) BO (1) NAS MIRAMAR (1) CAG (1)

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
 WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

Certified a true copy.

(b) (6)

Enclosure ( 4 )

FIGHTER SQUADRON NINETY-SIX  
Flight Schedule for: Monday, 12 August 1963

SDO: LT JG (b) (6)

SUNRISE: 0608  
SUNSET: 1941  
MOONRISE: 0045  
MOONSET: 1352

EV.	PILOT/RIO	MODEX	BRIEF				MISSION	CALL	CH	FUEL	REMARK
			L/R	ETE	ATD	ATE					
1.	LT (b) (6) LT JG (b) (6)		1130	2.0			AA			13.0	GIANT KILLER NOTE L
			1230								
			1430								
2.	LT JG (b) (6) LT JG (b) (6)		"	"			"		"	"	"
3.	LCDR (b) (6) LT (b) (6)		1315	2.0			"		"	"	"
			1715								
			1615								
4.	LT JG (b) (6) LT (b) (6)		"	"			"		"	"	"
5.	LCDR (b) (6) ENS (b) (6)		1500	2.0			"		"	"	"
			1600								
			1800								
6.	LT (b) (6) LT JG (b) (6)		"	"			"		"	"	"
7.	LCDR (b) (6) LT JG (b) (6)		1615	1.5			SPN-10		"	"	"
			1715								
			1845								
8.	LCDR (b) (6) LT (b) (6)		1615	2.0			AN-2		"	"	"
			1715								
9.	CDR (b) (6) LT (b) (6)		1830	1.3			AA-6		"	RUTH NOTE L	"
			1945								
			2100								
10.	LT (b) (6) LT JG (b) (6)		"	"			"		"	"	"
11.	LT (b) (6) LT (b) (6)		1845	1.7			AA-9		"	"	"
			2000								
			2145								
12.	LT JG (b) (6) LCDR (b) (6)		"	"			"		"	"	"
13.	LT JG (b) (6) ENS (b) (6)		1900	1.7			AA-14		"	"	"
			2015								
			2200								
14.	LT JG (b) (6) LT JG (b) (6)		1900	"			"		"	"	"

SCHEDULED SORTIES      SORTIES NO.      HOURS      HOURS MO.  
                8/6                                    15.379.5

NOTES: {1} BRIEF EMER #  
(2) CONTACT GIANT KILLER AIRBORNE  
(a) PR1 - 291.2  
      SEC - 339.6  
(b) TAC/N 14  
(c) OP AREA KK 22  
(3) BRIEF RUTH PRIOR TO LAUNCH

I certify that all pilots will be briefed on weather, flight plans, and other pertinent information in accordance with NATOPS, posses necessary maps/charts and hold a valid instrument card.

SUBMITTED:

APPROVED:

(b) (6) LT JG, USN  
Flight Officer

(b) (6)

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

CERTIFIED TO BE A TRUE COPY

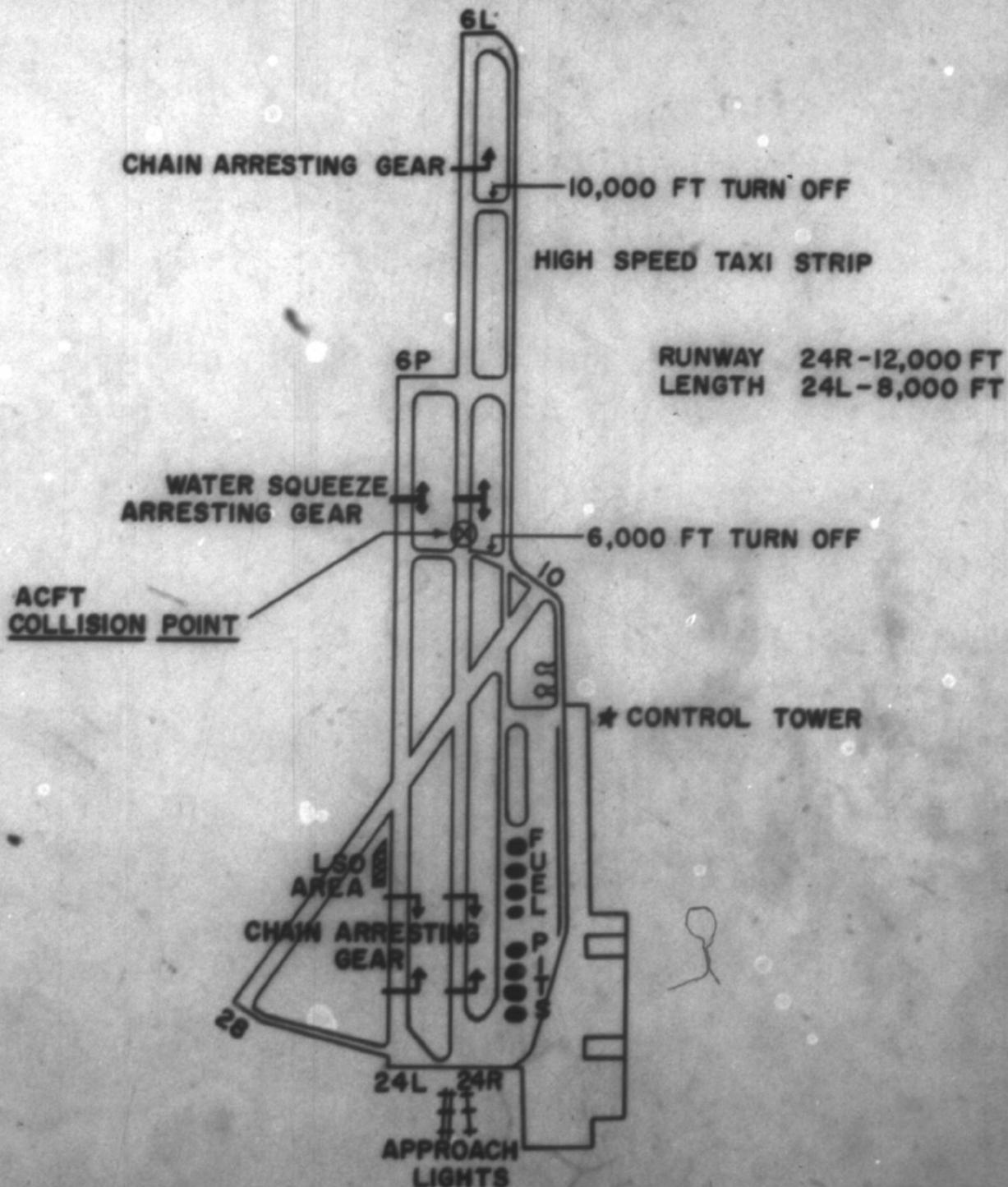
(b) (6)

Enclosure ( 5 )

# NAS MIRAMAR FIELD DIAGRAM

12 AUG 63

VF-114 SER I-63A/VF-96 SER 4-63A, INVOLVING F4B BUNO 148391 AND  
F4B BUNO 150645, PILOTS [REDACTED] (b) (6)



SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF  
OPNAVINST 3750.6E

ENCL (C)

STATEMENT OF (b) (6)

LTJG, USN, (b) (6)

PILOT OF F4B BUNO 150645

CONCERNING VF-114 SER 1-63A/VF-96 SER 4-63A 12 AUG 63, PILOTS (b) (6)

(b) (6)

At 1953 I took off as section wingman of ST 605 on a Seawolf Departure. After released from departure control we switched 309.8 MC for Ruthless Ruth control. After 3 successful intercept runs we determined that Ruth was not painting us and at this time ST 605's transmitter became very garbled. I told Ruth and 605 at this time that I would orbit 26 mi 260 radial NKX and for 605 to join, and I would take him in. As 605 became closer in proximity his radio transmission became clearer. I told him at this time that I would take him in on a Tacan #2 approach as briefed, and that if he established reliable comm. with approach control he could break off or wave off and shoot touch & go's as he had previously indicated. After 605 joined, I turned all lights to dim and steady for ease in flying formation and proceeded to the fix. We concluded a normal approach and GCA and I waved off to the box pattern for another GCA. At the conclusion of the 2nd GCA and wave-off, I switched tower frequency and entered the pattern. Tower frequency was very jammed at this time as MLP's had just been cancelled because of weather and all A/C were making finals. There was some low thin weather but at no time in the pattern did I lose sight of any part of the runway. On my first approach to the runway there was an A/C at the 45 as I was at the 90 who was not identified by the tower to my satisfaction and as I was inside of his turn radius I elected to go around. I concentrated on the traffic and the tower transmissions on my turn downwind and due to a wide 180 degree my second approach was angling. I elected to land on the left side of the runway because of the angle and I made a normal touchdown at about 128 K. After breaking to turnoff speed and seeing the approaching taxiway I called for turnoff at 10 but in actuality it was 6000 ft. The tower advised negative that there was an aircraft approaching behind so I added power and tried to get further left on the runway. At about this time there was a loud crash and the A/C swerved sharply left. The A/C made about a 200 degree turn and I braked to a halt. I advised the tower that I was hit and was shutting down which I did and both myself and my RIO LCDR (b) (6) exited the A/C. I have 641.9 hrs total flight time of which 352.8 is in the F4B. This accident might have been prevented had the tower instructed the following A/C that I was on the left side.

(b) (6)

LTJG

Identified a true copy

(b) (6)

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST P3750.6Z

Enclosure (9)

STATEMENT OF LCDR (b) (6) USNR, (b) (6) RIO OF F4B BUNO  
150645, CONCERNING VF-111 SER 1-63A/VF-96 SER 4-63A OF 12 AUG  
1963, PILOTS (b) (6)

Pilot LTJG (b) (6) and myself in ST 602 and ST 605 completed a section Tacan #2 approach with a wave off to enter the box pattern. After being radar vectored to the field we requested a wave off for a turn downwind to a final landing. At the 180 degree my pilot requested to land and was granted same by the tower. As we were approaching the 90 degree, my pilot and I saw another aircraft in our 11:00 position slightly lower than ourselves, yet seeming to be a little higher in altitude than the normal MLP pattern, thus LTJG (b) (6) interrogated the tower regarding this aircraft. No response was received, so rather than continue our descent, LTJG (b) (6) told the tower he was waving off, added power to the aircraft and waved off his final approach. Visibility was good at 2000' and no problem had been encountered at any time during our flight with our radio. My pilot and I conversed during our second attempt to land that there seemed to be some unexplained confusion regarding the landing of aircraft this evening. As we again were at the 180 degree, pilot LTJG (b) (6) requested to land and was given permission to land 24 Right. The approach was good and the touch-down speed indicated approximately 125 KCAS. Rollout seemed normal. As we passed the 6000' marker on the left side of 24R, pilot LTJG (b) (6) while continuing to slow down requested a "turn off" at 10' and continued rollout remaining on the left side. The tower replied to continue rollout as another aircraft was rolling up behind, or something to that effect. The next thing I can recall is a blow coming from the rear, and our aircraft commencing to skid.

(b) (6)

Certified a true copy.

(b) (6)

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

Enclosure (-13)

STATEMENT OF (b) (6) AC1 (b) (6) USN, TOWER SUPERVISOR CONCERNING  
VF-114 SER 1-63A/VP-96 SER 4-63A 12 AUG 53, PILOTS (b) (6)

I was the tower supervisor. I was working in the background, coordinating with aerology and the ODO, keeping them advised of some low clouds the tower observed west of the field and moving towards the field.

I heard an aircraft, I believe it was SHOWTIME 605 report clouds around 1000 indicated, and that he would check them on his next pass, (his intentions were touch and go). This was relayed to Aerology. The ODO was in Aerology, and he told me to keep an eye on the weather, and to land MLP when I thought it necessary. Another aircraft reported bases at 900' indicated. I could not see aircraft at pattern altitude cross wind or down wind. I could not see GCA traffic at 3 miles. At this time I told (b) (6) AC2 to take over supervising the traffic control, and to tell LSO to secure MLP due to weather.

By this time LINFIELD 406 had been cleared into MLP pattern after a GCA low approach, and I believe he got in at least one pass. SHOWTIME 602 who was given a 3 mile GCA wave-off by the tower entered down wind. On his first pass he waved off on his own, due to traffic I believe. SHOWTIME 602 was cleared down wind. LINFIELD 406 came out of MLP and was cleared down wind behind SHOWTIME 602. The controller asked 602 his position, and 602 said approaching the 180, the controller then told LINFIELD 406 his interval was an F4 approaching the 180. 406 said "Roger, I have interval." The tower was still trying to get the LSO to secure his MLP pattern, and to land them 24L on his frequency and at MLP altitude. The LSO never did comply. I was also attempting to get the field set IFR. (surface visibility from tower 5 to 6 miles). By this time SHOWTIME 602 had been cleared to land runway 24R. His interval was turning off 24R at 10,000. LINFIELD called at the 90 for full stop. The controller tried to set him up for 24L. 406 said he couldn't set up for the left at this time. 406 was then cleared to land number two behind an F4 for final. By this time the field was set IFR by direction of ODO. I advised GCA and San Diego Approach Control. I then observed LINFIELD 406 to be rolling out fast around 1500 down 24R and that SHOWTIME 602 was real slow around 5500, and dimly lighted. I called this to the attention of (b) (6)  
(b) (6) and he rogered it,

At this time Aerology called and said the weather was a M50. I looked up and 406 was still over taking 602. I again called it to the attention of (b) (6)  
(b) (6) About this time 602 called for a right turn at 10, (he was approaching the 6000' turn off) tower told 602 to roll out straight ahead. 602 said then understand cleared right. Tower said "negative continue rollout F4 closing on left side". (it appeared to me that 602 started a right turn then straightened out to runway heading) LINFIELD 406 was told caution an F4 rolling out 1000' ahead. I did not hear 406 acknowledge. LINFIELD 406 was slowing and it looked to me that 406 would pass 602 on the runway around 6200 or 6500'. LINFIELD 406 ran into 602 and I activated the crash phone. Both aircraft shut down on the runway. I insured that all runway and approach lights on 24R were turned off and that the appropriate parties were notified.

I have been an Air Controlman since 1955. I have been controlling aircraft at Miramar since May 1961. I hold a Junior Controllers rating for Miramar and a Senior's for San Diego area, dated 1957. I have controlled from North Island from August 1955 to August 1958, and from September 1958 to December 1960, I was CCA controller on USS GRISWOLD CVA-34.

(b) (6)

AC1

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 66 OF OPNLINST P3750.6B.

The Board considers the witness credible.

Certified a true copy

(b) (6)

Enclosure (11)

STATEMENT OF (b) (6) AC3, USN, (b) (6) TOWER  
OPERATOR, CONCERNING VF-11A SER 1-63A/VF-96 SER 4-63A OF  
12 AUG 1963: PILOTS (b) (6)

I stood behind "A" stand observing the aircraft in the pattern when the stratus layer to the west seemed to be moving in. The Tower was unable to hold the aircraft visual crosswind or downwind when at 2000'. A pilot reported a scud at 900' indicated. The ODO was advised of the situation and the field was placed IFR by the ODO.

The tower supervisor told the local controller to tell "paddles" to land his aircraft on runway 24L. This was done but "paddles" wanted to know who the ODO was that set field IFR. I plugged into "A" stand and told "paddles" to land his aircraft runway 24L at MLP altitude. "Paddles" came back with a "Roger" however, "paddles" had his aircraft contact tower for final. The aircraft climbed to 2000' before contacting the tower.

The section leader was controlling traffic on the backup gear when OLD NICK 115 came out of the MLP pattern. I was monitoring him from the normal "A" stand position. I was trying to help the section leader locate his aircraft in the pattern. I observed OLD NICK 115 at the 180 for the first time when he called the tower saying that he was at a wide 180. SHOWTIME 602 was ahead of OLD NICK 115 and advised the tower that he was going around. SHOWTIME 602 was given clearance downwind report base. LINFIELD 406 came out of MLP requesting downwind for final. 406 was given his interval and acknowledged, "I have him". I did not see 602 or 406 until pass the 180. SHOWTIME 602 was given clearance to land 24R number one. LINFIELD 406 was asked if he could set approach at 24L, 406 was then given clearance to land 24R number two following phantom on final. 602 was rolling past the tower when 406 touched down, however, 602 was rather slow on this rollout. 602 was just passed 5000' on runway 24R when he requested clearance for right turn off at 10,000'. At this time 406 was passing the tower approximately 3500'. 602 was told to continue rollout; 602 came back with "understand cleared right turn". Again the tower told 602 to continue rollout and was advised that a phantom was closing. 406 was advised that there was a phantom rolling out 1000' ahead.

I then heard a "bang" that sounded like a blown tire. When I saw the two aircraft swerving I yelled "hit the crash phone". 602 came out on tower frequency and said that he had been hit. 406 said likewise and that he was shutting down on the runway.

I then was "A" stand controller and told OLD NICK 101 to wave off and continue upwind. OLD NICK 101 was given instructions to switch to San Diego Approach Control 281.8.

Runway 24R was closed and GCA was advised to set approaches to 24L.

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E  
Certified a true copy.

Enclosure (12)

(b) (6)

STATEMENT OF (b) (6)

C3

(CONTINUED)

The statement above made to the best of my knowledge.

(b) (6)

AC3

My experience in the air traffic control field is as follows:

- a. Trainee at Miramar from February 1962 to June 1963
- b. Junior Controller 17 June 1963 to present
- c. Assistant section leader since 1 August 1963

Certified a true copy.

The Board considers this witness credible.

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

2

Enclosure (12)

STATEMENT OF [REDACTED] (b) (6) AC2, [REDACTED] (b) (6) USN, TOWER CONTROLLER  
GONE. NING VF-114 SER 1-63A/VF-96 SER 4-63A 12 AUG 63 PILOTS  
(b) (6) [REDACTED]

I took control of "A" stand (local control position) on the emergency UHF backup radio located between "A" stand and "B" stand due to weather conditions, traffic in the pattern, and local controller ("A" stand operator) in training stage not able to keep aircraft in the pattern in sight at west end of field (cross wind turn and downwind to the south, over highway 395 water tank).

At the time mirror landing practice (MLP) was in progress 24L, GCA approaches inbound to runway 24R.

Aircraft reported scud layer to west of field 9 hundred feet indicated. The Operations Duty Officer set the field IFR at 2130T.

OLD NICK 115 requested downwind entry from MLP. I cleared OLD NICK 115 downwind, 115 advised at a deep 180 position. I advised OLD NICK to report base leg. OLD NICK 115 reported base leg and was told to continue.

SHOWTIME 602 F4 advised Tower he was going around. I then cleared OLD NICK 115 to land 24R number 1. SHOWTIME 602 requested downwind entry, I determined position of 602 and cleared him for turn downwind.

LINFIELD 406 reported out of MLP for landing 24R. I advised LF 406 to maintain VFR and report downwind. I also told him of a phantom on downwind.

I then requested SHOWTIME 602 to give position, pilot reported downwind approaching the 180 position. I then told LINFIELD 406 that his interval was a phantom over the water tank and the pilot reported visual on his interval.

SHOWTIME 602 reported base for final landing. I advised him he was number two and cleared to land 24R. Pilot advised he did not see his interval, and was advised to continue.

I then requested OLD NICK 116 his position, pilot advised approaching 10,000 foot turnoff. I then cleared SHOWTIME 602 to land 24R number one. LINFIELD 406 reported base for landing, I requested 406 if it would be possible to make approach to 24L. The pilot reported "negative," not at this time. I cleared LINFIELD 406 to land runway 24R number two. Interval phantom on final.

SHOWTIME 602 on rollout runway 24R approximately 5,000 ft. marker requested right turn at "10" I told SHOWTIME 602 "to continue rollout" SHOWTIME 602 replied "understand cleared right". I replied "negative", continue rollout, phantom closing on the left side. I then told LINFIELD 406 phantom rolling out approximately 1000 ft. ahead.

At 2131T, LINFIELD 406 and SHOWTIME 602 collided on runway 24R at approximately 6,000 feet from approach end.

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST P3760.6E  
Certified a true copy

Enclosure Q3)

(b) (6) [REDACTED]

I heard what sounded like blown tires and impact sounds, I also observed sparks..

Throughout the time that I was controlling traffic, there were multiple transmissions on tower frequency from aircraft, the Tower, and the LSO on the field. Also San Diego Approach Control on UHF Guard Frequency.

The above statement made to the best of my knowledge.

(b) (6)

AC2

My experience in the field of air traffic control is as follows:

24 Months in the control Tower at MIRAMAR, 13 months of which has been as a qualified junior controller. Previous to MIRAMAR, 7 years throughout the fleet. (4 years Rear Field, 17 months aboard (CVA-16) 1 year at Midway Is. I am a graduate of Air Controlman "A" and "B" school.

The Board considers this witness credible

Certified a true copy

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNAVINST P3760.6E

STATEMENT OF (b) (6)

LT (b) (6)

USNR, RIO IN F4B BUNO 148391

CONCERNING VF-114 Ser 1-63A/VF-96 Ser 4-63A 12 AUG 63, PILOTS (b) (6)

I was RIO in Linfield 406, F4B-1 BUNO 148391 during the landing rollout which resulted in our ground collision with SHOWTIME 602.

We had just exited the MLP pattern, and were cleared by Miramar Tower for a downwind entry into the landing pattern for runway 24 right. Our touch down was smooth, and the initial part of the rollout normal. I was not aware of any unusual situation, until I experienced our aircraft swerving to the right, as if to commence a turnoff. Almost simultaneously with my noticing the swerve, the pilot called to me, "Head's up, head's up". I glanced out the left side of the cockpit and then experienced the sounds and vibrations of a collision. I did not know what we had struck, my initial thought being that we had run over some debris on the runway. Our aircraft proceeded to ground loop, and after it came to a halt, I released myself from my harness, and exited the aircraft. I have approximately 400 hours in the F4H, and have been a designated RIO since November of 1960.

(b) (6)

The Board considers this witness credible

Certified a true copy

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA. 66 OF OPNAVINST P3750.6E

Enclosure (15)

WEATHER REPORT  
AIRCRAFT EMERGENCY OR ON-STATION FIRE  
LIND-NAS-MIR-(DPS)-3140/1 (1-62)

EMERGENCY DATA			
CRASH ALARM SOUNDED AT <u>2030 2317</u> PST	STATION FIRE ALARM SOUNDED AT _____ PST	DATE <u>12 AUGUST 1963</u>	

AIRCRAFT/PILOT			
<input type="checkbox"/> A/C DEFERRED EMERGENCY	<input type="checkbox"/> A/C ACTUAL CRASH	<input checked="" type="checkbox"/> A/C CRASH DAMAGE	<input type="checkbox"/> PILOT INJURY
<input checked="" type="checkbox"/> A/C ACTUAL EMERGENCY	<input type="checkbox"/> A/C LANDED SAFELY	<input type="checkbox"/> A/C FIRE	

WEATHER DATA			
WEATHER OBSERVATION MADE AT <u>2030 2317</u> PST	DATE <u>12 AUGUST 1963</u>		

SURFACE WIND  
DIR 320 DEG(T) VELOCITY 64 KTS MAX. GUST: DIR NONE VEL NONE KTS

BAROMETER  
STATION PRESSURE 29.430 INS. ALTIMETER 29.93 INS. MSL 1013.1 MBS

TEMPERATURE  
AIR 67 OF DEW POINT 64 OF RELATIVE HUMIDITY 98 %

SKY COVER (Give type, amount and height of each layer present)

<input type="checkbox"/> CLEAR SKIES	<input checked="" type="checkbox"/> CLOUDS PRESENT	
TYPE OF CLOUDS <u>STRATUS</u>	TENTHS <u>8.6</u>	HEIGHT OF LAYER <u>500</u> FT
TYPE OF CLOUDS _____	TENTHS _____	HEIGHT OF LAYER _____ FT
TYPE OF CLOUDS _____	TENTHS _____	HEIGHT OF LAYER _____ FT

VISIBILITY  
PREVAILING 6 MILES LEAST VISIBILITY NONE MILES DIR \_\_\_\_\_  
TREND:  NO CHANGE  INCREASING  DECREASING  CHANGING SLOWLY  CHANGING RAPIDLY

RESTRICTIONS TO VISIBILITY (Check appropriate element if present at time)  
 FOG  GROUND FOG  SMOKE  HAZE  RAIN  SHOWERS  DRIZZLE  NO RESTRICTIONS TO VISIBILITY

REMARKS (Any pertinent weather not covered by the above)

= NONE

CERTIFIED TO BE A TRUE COPY

(b) (6)

SIGNATURE

(b) (6)

(b) (6)

(b) (6)

AG3

GC

DISTRIBUTION	AIRCRAFT/PILOT DATA
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Original: Weather Service File

A/C TYPE F4H LINE FIELD 406

If pilot injury or A/C damage occurs:

PILOT INJURY / (b) (6) CDR

3 Copies - Code 30 (For C.O. of squadron to which Pilot and A/C are attached)

UNIT TO WHICH A/C ATTACHED / (b) (6) CDR

1 Copy - Code 30 (Operations Officer)

1 Copy - Crash House/Fire Chief

SOURCE NAS MIRAMAR CALIFORNIA

VE-114

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 66 OF OPNAVINST P3750.6E

Enclosure (1?)

TRANSCRIPTION OF TOWER CONTROL POSITION TAPE CONCERNING COLLISION OF  
AIRCRAFT ON ROLL OUT ON 24 R 2131T 12 AUG 1963

<u>Time</u>	<u>Transmitting Station</u>	<u>Transmission</u>
2117	Showtime 605 Tower	MIRAMAR Tower Showtime 605 Downwind Showtime 605 above MLP Pattern cleared downwind Runway 24. Report Base with gear. MLP in progress.
	ST 605	605 Roger
2118	ST 605 Tower	MIR Tower ST 605 at the 180 gear down and locked request a touch and go on the right ST 605 continue approach will advise for 24 right 605 Wilco
	ST 605 Tower	Showtime 605 what were the bases of the fog when you went into it over 605 about 1000 feet
	ST 605 Tower	Roger was that indicated Roger something like that I'll check it next pass for you
2119	Tower Tower	ST 605 have a GCA aircraft for downwind entry about 4 miles now Roger tally ho
	ST 605 Tower	605 are you in front of the GCA aircraft Affirmative
	ST 605 Tower	Roger cleared touch and go 24 right
2120	V48399 Tower V48399 Linfield 400	Miramar Tower Navy Jet 48399 take off one 48399 hold short Roger holding short Miramar Tower Linfield 400 15 north for MLP. Method 2 please Linfield 400 call Camp Elliott 2500 for the break to Runway 24. Wind light and variable altimeter 2994. MLP in progress over 2994
	Tower	Miramar Tower Linfield 406 from a GCA wave off for downwind entry into MLP.
	LP 400 Linfield 406	Linfield 406 your internal is a F4 low cleared downwind number 2
2121	LP 406 ST 605 Tower	406 Tower 605 am I cleared downwind 605 cleared downwind maintain VFR looks like you're going into the scud now.
	ST 605	605 Roger The bases are 900 feet indicated over
	Tower Tower	Roger Showtime 604 maintain VFR downwind. You're number two.

<u>Time</u>	<u>Transmitting Station</u>	<u>Transmission</u>
	Paddles Background not very loud but clear in some places	406 downwind - garbled - Roger Zero six I believe I'm turning inside of you. Do you have a bird in sight Thats affirm Roger I'm in the pattern also -Garbled- Roger 116 21
2122	ST 605  Tower  ST 605  Tower  ST 605 Tower Tower Tower	Miramar Tower 605 I have somebody in my 10 o'clock position pretty close. 605 do not have another aircraft at that position over. 605 I'm over the water tower there's another one about 500 yards in front of me. 605 do not have - I have you in sight but I do not have your bogey over. He's in my 10 o'clock 604 your present position Showtime 604 your present position Showtime 604 I have you over astronauts
2123	ST 605  Tower  ST 605 Tower  ST 605 Tower  Tower  San Diego Approach Control  Tower ST 605	Miramar 605 is turning base down and lock for a full stop. Showtime 605 Roger have you in sight have a GCA aircraft 6 miles. Roger tally ho 605 can you take interval on the GCA aircraft at disregard that the GCA aircraft has been waved off cleared to land 24 Right. 05 Roger I'm at the 90 there's somebody behind me. 605 Roger have two ----- garbled by a transmission on Guard.
		Linfield 417 San Diego approach control on guard if you receive ident. 604 are you on final 605's on final
2124	Tower ST 605 Tower Showtime 602  Tower  ST 602 LF 400 Tower	Roger 605 cleared to land number 2 05 there's nobody ahead of me Roger 05 cleared number 1 This is Showtime 602 on GCA waveoff requesting downwind for final Roger showtime 602 cleared downwind remain wide of GCA pattern and maintain VFR downwind ceiling indicated 900. 602 Wilco. Linfield 400 Elliott one for MLP please Linfield - Broken in by old nick 115

<u>Time</u>	<u>Transmitting Station</u>	<u>Transmission</u>
	Old Nick 115	Miramar Tower Old Nick 115 is pulling off MLP for final landing.
	Tower	Linfield 400 descend to MLP Pattern cleared paddles frequency for interval.
	Tower Back Up (Section leader using standby radio equipment)	105 request position.
2125	Paddles in background	(Garbled) Climb up straight ahead go to tower for final
	Tower B.U.	Old Nick for the final say your position
	ON 115	This Old Nick 115 I'm at a wide 180. I have the Linfield aircraft in sight I believe.
	Tower B.U.	Understand a wide 180 now
	ON 115	Thats affirmative
	Tower	Old Nick 115 check the base gear down and locked.
	ON 115	Wilco
	ON 115	Would you notify one eleven aircraft taxiing out for MLP that that period will commence at 2200 over
	Tower	Old Nick will do
	Old Nick 101	Tower this is old Nick 101 cross wind for final.
	Tower B.U.	Old Nick 101 maintain MLP altitude and caution on downwind.
	ON 101	101 say again
	Tower	101 maintain MLP altitude and ... Garbled ....
	ON 101	101 I'm already at 2000 ....
	Tower	Roger 101 and Report base 24 Right
	ON 101	Roger
2126	ON 115	Old Nick 115 is at the - thru the 90 I have two aircraft in front of me on final - (some garble with another transmission)
	Tower	115 Stand by
	Tower	... Garbled ..... Aircraft 24 left
	Background	.... says land your aircraft over
	Showtime 602	What do you mean I can see them
	Tower	This Showtime 602 going around
	ST 602	Roger Showtime 602 GCA waveoff now 1 mile east
	Background	02 Roger tally-ho.
	Tower	406 at 3 well 4000 at the 90 -
	Background	Roger I don't have any trouble holding anybody tower
	Tower	Linfield 400 advise MLP period has been cancelled due to low scud layer over the field. Below minimums.
	Background	Roger who's the CEO

<u>Time</u>	<u>Transmitting Station</u>	<u>Transmission</u>
	Tower B.U.	400 fuel permitting contact San Diego Approach Control 281.8 for approach Standby I'll get the ODO's ..... Miramar Tower Linfield 31 Alfa request downwind for MLP over
	Background LF 31A	
2127	Tower B.U.	Linfield 31A contact approach control 281.8 for an approach. Field is going below MLP minimums.
	ON 115	Old Nick 115 is on a short final for final landing.
	Tower B.U.	115 cleared to land 24 Right number one aircraft short final 24 left your call
	ST 602	This is showtime 602 over the field I'd like downwind for final.
	Tower B.U. ST 602	02 understand over 24 Left now Two I'm over 24R passed the tower
	Background	Paddles tower land your aircraft on 24 Left or depart the pattern over
	Paddles	Zero six close your dump valves. Say again Tower
	Background	Paddles Tower. Land your aircraft at this time or depart the pattern over
	Paddles	I'd love to I can't crawl up (there) in them.
	Background	406 switching to tower frequency for final Landing
	Paddles	Roger Zero Six.
2128	Paddles	Tower if you'd turn down these Runway lights I could help you.
	Tower	Paddles Tower land your aircraft on the left runway.
	Tower	Paddles Tower land your aircraft MLP altitude on 24 Left.
	Paddles	Roger. All aircraft MLP freq ..... garbled... garbled.... downwind for final landing.
	Tower B.U.	406 Roger. Hold another phantom on downwind turn?
	LF 406	406
	Tower B.U.	602 request your position now
	ST 602	602 approaching the 180
	Tower B.U.	Roger 602 approaching the 180, 406 your interval is an F4 approaching the 180.
	LF 406	406 I have interval
	Tower B.U.	Roger
	LF 31A	Tower Linfield 31 Alfa over
	Tower B.U.	31A Tower
	LF 31A	Roger Approach control advises the field is still VFR over
	Tower B.U.	Linfield 31 Alfa the field is being set IFR by the Operations Duty Officer due to the restricted visibility and scud later reported at 900 feet indicated over the western end of the field.
2129		

Time	Transmitting Station	Transmission
	31 Alfa	Roger I just flew over the field and the visibility is down to about 4 miles but its still VFR
	ST 602	This is 602 (transmission interrupted)
	Tower B.U.	31 Alfa Standby
	ST 602	Gear indicating down and locked
	Tower B.U.	Showtime 602 Roger you're number 2 cleared to land 24 Right your interval just (at) the 45.
	ST 602	602 no joy my interval
	Tower B.U.	Roger 602 continue
	Tower	Old Nick 116 position
	ON 116	Approaching the 10,000 turnoff.
	Tower	Roger 116 ..... Garbled.... Break
	Tower	Showtime 602 number one cleared to land 24 right wind 200 degrees at five
	ST 602	Zero two
	Tower B.U.	Linfield 406 set approach 24 left
	LF 406	406 passing through the 90 for final landing
	Tower B.U.	406 would it be possible to set approach 24 left.
	LF 406	406 not at this time
2130	Tower	406 cleared to land 24 Right number 2 following the Phantom on final
	Background	Roger you've got a final on the Right
	31 Alfa	31 Bravo from Alfa detach and make your own...
	31 Bravo	31 Bravo go ahead
	31 Alfa	(Pancake) time over
	Background	You cut yourself out of about 800 feet of runway. Got a little low ball — garbled — garbled — garbled — garbled — over
	31 Bravo	Roger detach and make your own pancake time
	31 Alfa	A Roger
	31 Bravo	Thirty—event 31 Alfa and Bravo this is 400 going to Elcentro over
	Linfield 400	Roger
	?	31 Alfa — Garbled
	?	602 turn off at 10
2131	Showtime 602	602 — Garbled — Roll out
	Tower BU	Two understand cleared right
	ST 602	602 continue rollout F 4 closing on left side
	Tower BU	406 caution the F 4 about 1000 feet ahead rolling out.
	?	Linfield 400 are you still up
	?	That is — (broken by next transmission)

<u>Time</u>	<u>Transmitting Station</u>	<u>Transmission</u>
	ST 602	Zero Two I've been hit
	?	Roger zero two
	Linfield 406	This is 406. I'm shutting down on the runway
2131 3/4	ST 602	O2 likewise
	Tower BU	Roger

BU--means backup gear in the control tower being utilized by the controller

Background--means transmissions overheard by the recorder unintentionally.

ST = Showtime

LF = Linfield

(b) (6)

STATEMENT OF LT [REDACTED] USNR, (b) (6) VF-121 Landing Signal Officer, concerning VF-114 SER 1-634/VF-95 SER 4-63A 12 August 1963, PILOTS  
(b) (6)

I was the controlling Landing Signal Officer at N.S Miramar during the periods preceding the accident involving NH 406 and NG 602.

By prearrangement with LT (b) (6) LSO OF VF-114, I controlled the night FCLP periods involving civilian aircraft. VF-111 had completed an earlier period (2000-2030), and were completing a turnaround period with VFP-63 aircraft (2030-2100) as the VF-114 aircraft appeared for their period.

NH 406 (LINFIELD) entered the pattern upwind following a GCA, but reentered via Camp Elliott, due to the overloaded pattern. Shortly after, NH 400 entered the pattern from Camp Elliott, so I immediately cleared all the VF-111 aircraft to "tower" for final landings.

Normal congestion mounted at this time, which is normal at the completion of an FCLP period. This was further compounded because of several facets. It was night, plus there were four other aircraft, some with "steady", and some with "flashing" lights, shooting "touch and gos", and or making final landings on 24R.

About the same time, I was advised by the tower that the field had gone IFR, and that all aircraft should make final landings or depart the pattern. My immediate reaction was, "IFR?". Although it was hazy, I could not see any cloud coverage. I could hold all aircraft in the area, including GCA traffic up to at least five miles, and see the flashing lights on Mt. Soledad, which has always been an outstanding indication for visibility.

NH 406 was now approaching the 90° position for his first pass, and NH 400 "bingoed" to MAF ELCentro out of the downwind leg. Several transmissions were cut out by the noise of the aircraft around the field. After NH 406 touched down in the FCLP he switched to "tower" for a final. I called the tower for transportation and switched my radio to tower frequency.

I watched the approach of NH 406 as he passed through the 90° position for his final. The first transmission I heard on tower frequency was the end of a transmission, "24L". Hearing this, I expected NH 406 to land on the left, until he said, "Not at this time". I further backed up the tower to make doubly sure that NH 406 held the final ahead of him.

During the rollout, I heard NG 602 call for a turnoff at 10, and tower said, "continue rollout". With this, I secured my radios and started for the Gertie truck. Immediately the tower alerted the crash equipment about an accident at 6000 feet. I told the driver to go ahead and that I would secure the mirror.

I did not see the accident occur. As I was walking up 24R to the scene of the accident, I again looked for cloud coverage, of which there was none.

I have been a Naval Aviator for eight years and an LSO for five years.

(b) (6)

Certified to be a true copy

(b) (6)

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66 OF OPNL VINST 3750.6E

DAMAGED AIRCRAFT CONDITION AND DISPOSITION REPORT  
NAVAER-2980 (Rev. 6-59)

Submit original and one copy without letter of transmittal to the cognizant Bureau of Aeronautics Maintenance Representative and one copy to the following activities: (1) NAVAVNSAFEACTY NAS Norfolk, (2) Controlling Custodian, (3) OGR, (4) Reporting Custodian, (5) Log Book, (6) Controlling Activity (if ferry aircraft), (7) ComNAB, (if ferry or other transient aircraft and a ComNAB is concerned), and (8) Ferry Squadron, (if concerned).

OF AAR

Aer-Rep MA-73

8-12-63

FROM	Commanding Officer, NAS North Island, San Diego 35, California		SERIAL NUMBER	60-63	DATE	15 August 1963
TO	BUREAU OF AERONAUTICS MAINTENANCE REPRESENTATIVE		BUWEPSFLTREADREP PAC			
REFERENCE	(b)					
(a) LATEST ISSUE OF BUAEER INSTRUCTION NAVAER 00-36						
DATE OF ACCIDENT OR DAMAGE	LOCATION OF AIRCRAFT		REPORTING CUSTODIAN			
12 August 1963	NAS MIRAMAR		VF-114			
AIRCRAFT MODEL	SERVICE PERIOD	ENGINE MODEL				
F-4B	1	J79-GE-8				
BUREAU NUMBER	MONTHS THIS SERVICE PERIOD	ENGINE DATA	PORT		STARBOARD	
148391	10 Period	ENGINE BUREAU NUMBER	401463		401508	
STATUS (Flyable, non-flyable)	FLIGHT HOURS THIS MONTH	TIME ON ENGINE(S) SINCE NEW	202.1		196.3	
Non-flyable	11.3	TIME ON ENGINE(S) SINCE OVERHAUL	none		none	
ACCEPTANCE DATE	FLIGHT HOURS THIS TIME					
2 August 1961	188.6 Period					
TOTAL OVERHAUL-PAR'S	FLIGHT HOURS SINCE NEW					
0	225.6					

DETAILED DESCRIPTION OF DAMAGE AND REMARKS

SEE ATTACHED SHEET.

ESTIMATED COSTS OF LABOR AND MATERIAL NECESSARY TO PLACE AIRCRAFT IN COMPLETE SERVICEABLE CONDITION

REPAIR ONLY

TOTAL MANHOURS	DIRECT	2,300
	INDIRECT	
TOTAL MANHOUR COST		\$ 21,321.00
NON-REPAIRABLE ASSEMBLIES COST		\$ 31,000.00
MATERIAL COST		\$ 8,000.00
SHIPPING OR TRANSPORTING TO OGR		\$
TOTAL COST		\$ 60,321.00

RECOMMENDED DISPOSITION

Aircraft be delivered to NAS NORIS, Overhaul and Repair Department, for Repair concurrent with PAR.

The following preparatory work shall be accomplished by the operating unit prior to acceptance by the Overhaul and Repair Department for repair:

- a. Remove ammunition, pyrotechnics and ejection seat charge.
- b. Remove spare and loose gear.
- c. Preserve engine(s).
- d. Drain and purge fuel cells and disconnect battery.
- e. Bring log books up-to-date and deliver with aircraft.
- f. Inventory aircraft and retain copy for reference.

ESTIMATED INDUCTION DATE FOR REPAIR (Contingent on availability of material)

ESTIMATED COMPLETION DATE

29 August 1963

20 December 1963

COPY TO

NAVAVNSAFEACTY NAS Norfolk

Controlling Custodian

COMNAVAIRPAC

OGR Department

Reporting Custodian

VF-114 (Attn: Maint. Officer)

Log Book

COMFAIR SDIEGO (70 DIV., BLDG. 626)

BUWEPS (FPWR-5)

SIGNATURE OF PLANNER AND ESTIMATOR

(b) (6)

SIGNATURE

(b) (6)

By direction

By direction

Z-60289

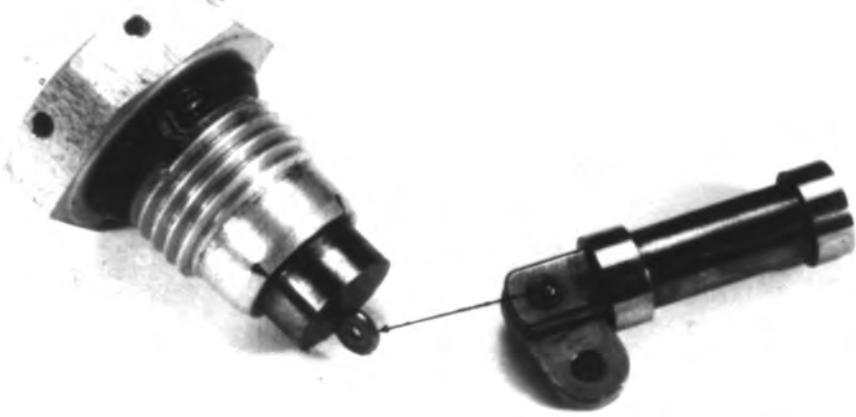
DAMAGE REPORT F-4B BU NO. 148391

1. Left side Radome damaged. (Repair)
2. Left side fuselage skin supporting structural ribs, and formers damaged from C.F.S. 44.25 to C.F.S. 134.50. (Repair)
3. Variable ramp damaged. (Repair)
4. Left air intake duct damaged to inner skin, outer skin, structural ribs and formers from C.F.S. 167.60 to F.S. 308.31. (Repair)
5. Structural damage left side fuselage, from door 47L to door 39L. (Repair)
6. Left side fuselage skin, ribs, and spoilers damaged from door 47L to aft engine door.
7. Left outer wing panel damaged beyond repair. (Replace)
8. Left outer wing leading edge flap, damaged beyond repair. (Replace)
9. Left inner wing leading edge flap damaged. (Replace)
10. Left inner wing leading edge damaged at station BL 138.72 to BL 160.00. (Repair)
11. Comply with G.G.T.E.B. 38 - Port engine due to F.O.D.

NOTES: 1. OPNAVINST P3750.6E Estimate 1,800 Man-hours.

1. OVERHAUL ACTIVITY NAS, NORIS		2. REPORT NO. 653	3. DATE OF O/I 10-14-63	4. ASSEMBLY Nomenclature AND PART NO.			ENGINE <input checked="" type="checkbox"/>
5. ASSEMBLY (Model) J79-GE-8	6. ASSEMBLY (Sub-Asy) 401 463	7. ASSEMBLY NO. 94791	8. DATE REMOVED 9-10-63	9. REMOVED FROM (Eng Bed) --	10. REMOVED FROM (Eng Ser) S284CD		
11. TOTAL HRS 202.1	12. HRS SINCE LAST O/H --	13. DATE LAST O/H --	14. LAST OVERHAUL ACTIVITY --	15. NO. PREV O/H'S --	16. AIRCRAFT (Model) PiH-1	17. AIRCRAFT (SER) 148391	
18. OPERATING ACTIVITY VF 114		19. FUR-EFR-AAR-1/PA/6A		20. REASON FOR REMOVAL AND CODE EXTENSIVE F.O.D. & A/C CRASH DAMAGE SC			
21. FINDINGS <input type="checkbox"/> NO DISCREPANCY		<input checked="" type="checkbox"/> BASIC (MFG/DESIGN) DISCREPANCY	<input type="checkbox"/> NON-BASIC (MAINT/OPR) DISCREPANCY	<input checked="" type="checkbox"/> FOREIGN OBJECT DAMAGE			
22. PRIMARY PART FAILURE (Part No.) COND. ZONE 512D866P1 192 99							
23. DISCREPANT PARTS (Part No.) COND. 512D715P3 185 107R880G1 574 515D581G3 381							
24. PERTINENT BULLETINS, CHANGES, ETC., INCORPORATED NUMBER YES NO							
25. REQUESTED BY <input type="checkbox"/> PRIORITY DIR SD. SIGNATURE (b) (6)		26. TITLE Power Plant Div. Supt.		27. APPLICABLE SRED 114 INCORPORATED		28. DATE 10-15-63	

DISASSEMBLY AND INSPECTION REPORT NAVFMS FORM 4730/2 (II-61) REPORT SYMBOL BUNEP 4730-2



NOZZLE AREA PUMP  
P/N 512D866P1  
ENG. MOD. J79-GE8  
SERIAL NO. 401463  
SEQ. NO. 5-284  
ENCLOSURE (1)



NOZZLE AREA CONTROL  
P/N 512D715P3  
S/N 5395588  
ENG. MOD. J79-GE8  
SEQ. NO. 5-285  
ENCLOSURE (2)



VF-114, SER 1-634, F4B, 148391 (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) DAMAGE TO  
F4B 150645 TAIL HOOK, AFTER ENGINE SECTION, AND STABILATOR. SPECIAL HANDLING REQUIRED  
IN ACCORDANCE WITH P.R. 66, OPNAVINST P3750.6E. ENCLOSURE (1A)



VF-114, SER 1-63A, F4B, 148391, (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) PORT  
OUTER WING PANEL AND FUSELAGE DAMAGE TO F4B 148391 SPECIAL HANDLING REQUIRED IN  
ACCORDANCE WITH PARA 66, OPNAVINST P3750.6E. ENCLOSURE (18)



VF-114, SER 1-63A, F4B, 148391, (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) STARBOARD  
OUTER WING DAMAGE TO F4B 150645 SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66,  
OPNAVINST P3750.5E ENCLOSURE (1C)



VF-114, SER 1-<sup>2</sup>, F4B, 148391, (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) FUSELAGE  
AND WING DAMAGE TO F4B 148391 SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66,  
OPINVNGT P0750.6E ENCLOSURE (I-D)



VF-114, SER 1-63A, F4B, 148391, (b) (6) VF-96, SER b-63A, F4B, 150645, (b) (6) RUPTURED  
STRESS PLATE FS 613.44 TO FS 600.00 AND FRACTURED STABILATOR ATTACH POINTS ON F4B  
150645. SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66, OPNAVINST P3750.6E.  
ENCLOSURE (1E)



VF-114, SER 1-63, F4B, 148391 (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) DAMAGE TO  
F4B 150645 TAIL HOOK, AFTER ENGINE SECTION, AND STABILATOR. SPECIAL HANDLING REQUIRED  
IN ACCORDANCE WITH PARA 66, OPNAVINST P3750.6E. ENCLOSURE (IA)



VF-114, SER 1-63A, F4B, 148391, (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) PORT  
OUTER WING PANEL AND FUSELAGE DAMAGE TO F4B 148391 SPECIAL HANDLING REQUIRED IN  
ACCORDANCE WITH PARA 66, OPNAVINST P3750.6E. ENCLOSURE (16)



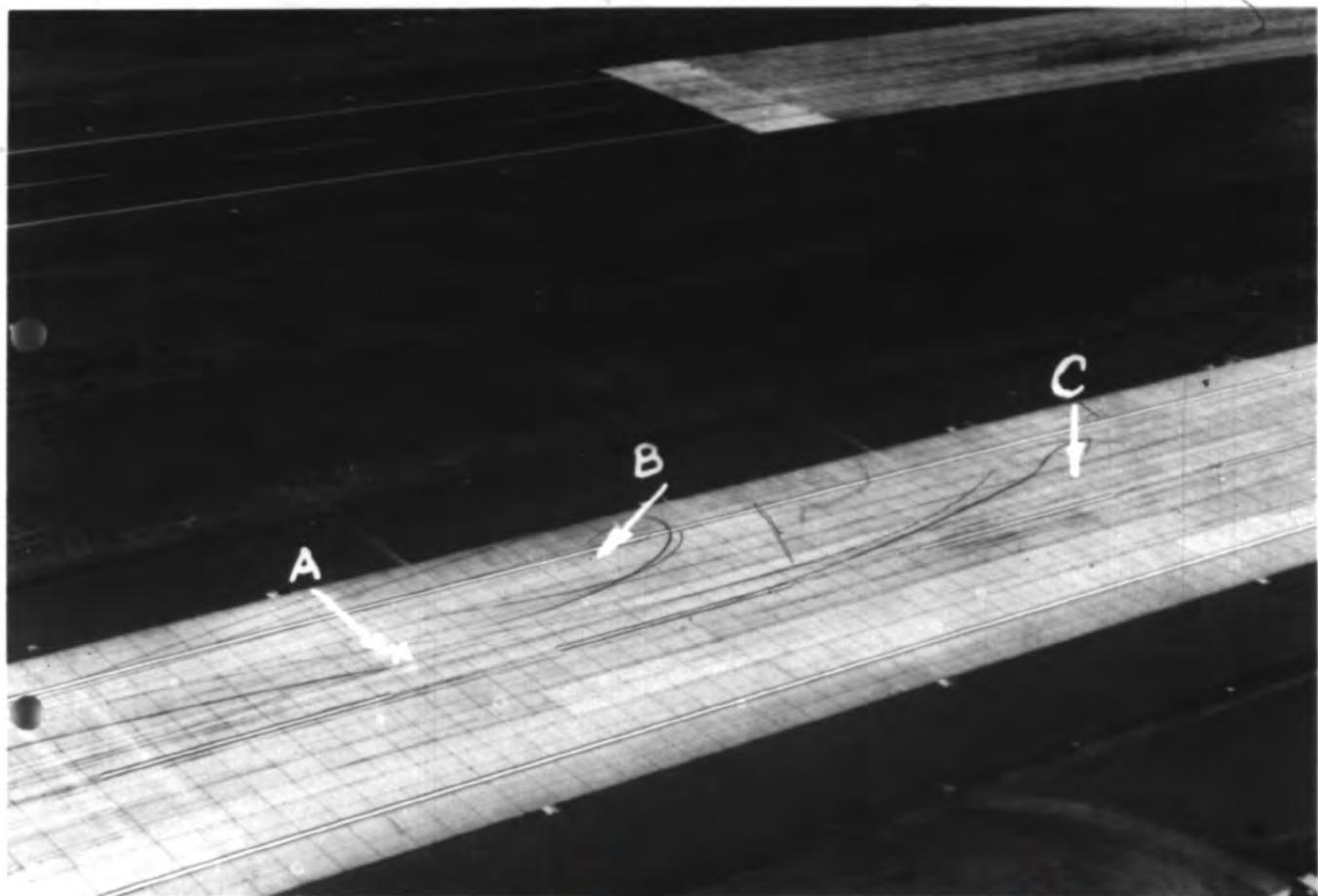
VF-114, SER 1-63A, F4B, 148391, (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) STARBOARD  
OUTER WING DAMAGE TO F4B 150645 SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66,  
OPNAVINST P3750.6E ENCLOSURE (1C)



VF-114, SER I-~~31~~, F4B, 148391, (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6) FUSELAGE  
AND WING DAMAGE TO F4B 148391 SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66,  
OPNAVINST P3750.6E ENCLOSURE (1-D)



VF-114, SER 1-63A, F4B, 148391, (b) (6) VF-96, SER 1-63A, F4B, 150645, (b) (6) RUPTURED  
STRESS PLATE FS 613.44 TO FS 600.00 AND FRACTURED STABILATOR ATTACH POINTS ON F4B  
150645. SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 66, OPNAVINST P3750.6E.  
ENCLOSURE (1E)



VF-114, SER 1-63A, F4B, 148391, (b) (6) VF-96, SER 4-63A, F4B, 150645, (b) (6)  
PHOTOGRAPH SHOWING SKID MARKS ON RUNWAY 24R NAS MIRAMAR. COLLISION OCCURRED  
AT APPROXIMATELY 6260 FT FROM APPROACH END. A-IMPACT POINT, B-FINAL POSITION  
F4B BUNO 150645, C-FINAL POSITION F4B BUNO 148391. SPECIAL HANDLING REQUIRED  
IN ACCORDANCE WITH PARA 66, OPNAVINST P3750.6E. ENCLOSURE (16)

## SECTION A - IDENTIFICATION

1. FROM (NAME AND MAILING ADDRESS OF ACTIVITY) VF-111, FPO, SAN FRANCISCO, CALIFORNIA					2. NOR NO. 1-63	3. LEAVE BLANK								
4. TYPE OF MISCHAP GROUND <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> INCIDENT		5. TIME & ZONE 2131 T	6. DATE 12 AUG 63	7. GEOGRAPHICAL LOCATION NAS MIRAMAR, CALIFORNIA										
8. MODEL A/C 9. BUND F/A-18 1148391		10. NO OF OC- UPANTS 2	11. DAMAGE NONE	12. UNIT OPERATING A/C VF-111	13. INDIVIDUALS INVOLVED USE ADDITIONAL SHEETS IF REQUIRED.	14. UNIT TO WHICH ATTACHED	15. RANK/ RATE	16. FILE/ SERVICE NO. DESIGNATOR	17. DUTY ASSIGNMENT ABOARD AT A/C MISCHAP	18. DRIZZ LAFF PHYSICAL CONDITION OF PERSONNEL ON BOARD	19. BRANCH OF SERVICE	20. GRADE	21. INJURY CODE	22. DIMINISHES
					(b) (6)	VF-111	CDR	A A	12 AUG 27 JUN	Yes	USN	G	I	
						VF-111	LT	K K	C	Yes	USN	G	T	
23. CLARIFICATION OF ITEMS 13-22 WHEN NECESSARY. N/A														
24. MODEL OTHER A/C IF INVOLVED F/A-18		25. BUND 150615	26. NO OF OTHER OCCUPANTS 2	27. UNIT OPERATING A/C VF-96	28. DAMAGE NONE	29. NOR NO. 1-63-A								
30. NARRATIVE ACCOUNT OF MISCHAP (USE ADDITIONAL 8 X 10 <sup>1/2</sup> PLAIN SHEETS IF REQUIRED)														

See attached addendum.

31. PRIMARY CAUSE FACTOR ASSIGNED BY ACCIDENT BOARD	Pilot error, CDR (b) (6)		
32. CONTRIBUTING CAUSE FACTOR ASSIGNED BY ACCIDENT BOARD	1. Other pilot error (LTJG (b) (6)) 3. Weather 2. Facilities personnel (Control Tower and LSO).		
33. POSSIBLE CAUSE FACTOR ASSIGNED BY ACCIDENT BOARD	N/A		
34. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO HAVE ALL FINDINGS, CONCLUSIONS & RECOMMENDATIONS BEEN MADE AVAILABLE TO THE A/C ACCIDENT BOARD? IF NO EXPLAIN			
35. REPORT PREPARATION CHECK LIST <input checked="" type="checkbox"/> 1. AIRCRAFT <input checked="" type="checkbox"/> 2. WEATHER <input checked="" type="checkbox"/> 3. FACILITIES <input checked="" type="checkbox"/> 4. PERSONNEL	SURVIVORS NARRATIVES	WITNESS STATEMENTS	CONCLUSIONS AND RECOMMENDATIONS
36. (b) (6)	DATE 29 AUG 63	37. DESIGNATED CHIEF A/S COMM. LINE OF APPOINTING CDR USN ENCLOSURE (1)	DATE 29 AUG 63
(b) (6)	(b) (6)		

ADDENDUM. Page 1, No. 30:

(b) (6) (b) (6) of VF-114 and LTJG (b) (6) of VF-96 were scheduled for night training flights in the F4-B. Cdr. (b) (6) was scheduled for a night MLP period and LTJG (b) (6) for a night air intercept flight as section wingman.

About 2120 NAS Miramar was conducting FMLP on runway 24L and VFR/IFR/GCA traffic landings on 24R. The field was declared IFR at this point because of increasingly poor visibility and all local traffic ordered to land or depart the field boundaries.

LtJG (b) (6) (ST 602) entered the pattern for a final on 24R with lights dim and steady. On the second approach he landed on the left side of 24R. ST602 slowed to turn-off speed by 6000 ft.; mistakenly, LtJG (b) (6) thought he was at 10,000 ft.

Cdr. (b) (6) (LF 406) entered the pattern behind ST602 on his second downwind. LF406 had ST602 in sight as LF406 gave the 180° report. At the 90° position, LF406 lost sight of ST602. As Cdr. (b) (6) continued his approach, he thought he spotted St602 landing on the right side of 24R, and proceeded to land on the left side of 24R, being cleared to land by the tower with a short interval (about 4000 feet).

When LF406 was approximately 1000feet behind ST602 on the runway, tower denied ST602's request for an early turn-off and noted that LF406 was closing close behind. Cdr. (b) (6) began light braking at this time, but could not make out the aircraft outline until he was less than 200 feet behind, and then commenced a hard swerve to the right. Impact occurred at 6260 feet along the runway, and the impact momentum pivoted ST602 to the left and LF406 to the right. Both aircraft remained on the runway; both aircraft sustained Bravo damage. No injuries.

## SECTION A

FACTORS CONTRIBUTING TO OR RELATED TO MISHAP BY PHASE OF MISHAP  
(LIST IN ORDER, IN ACCORDANCE WITH SECTION B OF INSTRUCTION)

1. FACTORS	2. * PHASE OF MISHAP				*PHASE CODE	A-ACCIDENT S-SURVIVAL	E-ESCAPE/EGRESS R-RESCUE
	A	E	S	R	FACTOR WEIGHT	M-MAJOR C-CONTRIBUTING Q-QUESTIONABLE OR POSSIBLE	(REMARKS)
Poor choice of action	M	N/A	N/A	N/A			Upon losing sight of preceding a/c, Cdr. (b) (6) should have waved-off.

## SECTION C

## AIR CREW DATA

1. FLIGHT TIME LAST 30 DAYS (ALL MODELS)	1.8		
2. FLIGHT TIME LAST 24 HOURS (ALL MODELS)	1.8		
3. NUMBER OF FLIGHTS LAST 24 HRS (INCLUDE PRESENT FLIGHT)	2		
4. TIME AT CONTROLS THIS FLIGHT	0.8		
5. TOTAL FLIGHT TIME ALL MODELS	3886		
FLIGHT TIME THIS MODEL	6. TOTAL	LAST 30	8. 60
	4.47	1.8	16
			58
10. NO. GROUNDBINGS PAST YEAR	1		
11. NO. DAYS GROUNDED PAST YEAR	21		
12. DATE AND TYPE OF PRIOR MISHAPS			
Nov. 1956-Engine seizure-ejected			
Jan. 1957-FOD on takeoff-Bravo damage			
13. NO. HOURS IN A DUTY STATUS LAST 24 HOURS	13		
14. DIRECTION FACING AT TIME OF MISHAP: forward			
15. LOCATION AT TIME OF MISHAP: forward cockpit			

## "LABORATORY TESTS AND RESULTS"

SPECIMEN	TEST PERFORMED	RESULTS	SPECIMEN	TEST PERFORMED	RESULTS
BLOOD 1.	NONE		TISSUE: (CNS)	NONE	
2.			MUSCLE		
3.			VISCERA		
URINE:			OTHER:		
G.1. CONTENT					

17. X-RAY RESULTS      NONE

NON ID'd 1-63A	MODEL #/C F4-B	BONU 1148391	IDENTITY Cdr. (b) (6)
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## SECTION A

FACTORS CONTRIBUTING TO OR RELATING TO MISHAP BY PHASE OF MISHAP.  
(LIST IN ORDER, IN ACCORDANCE WITH SECTION B OF INSTRUCTION)

1. FACTORS	2. * PHASE OF MISHAP				*PHASE CODE	A-ACCIDENT S-SURVIVAL	E-ESCAPE/EGRESS R-RESCUE
	A	E	S	R	FACTOR WEIGHT	M-MAJOR C-CONTRIBUTING Q-QUESTIONABLE OR POSSIBLE	(REMARKS)
1. Faulty judgement of distance on runway	M	N/A	N/A	N/A			Pilot thought he was at 10,000 feet along runway when he was actually at 6,000 feet and had slowed to turnoff speed.
2. Inadequate use of exterior lighting	M	N/A	N/A	N/A			SOP at Miramar for planes in pattern is for lights to be bright and flashing. The lights of LTJG [REDACTED] plane were dim and steady. The Grimes light was not in use. (b) (6)

## SECTION C AIR CREW DATA

1. FLIGHT TIME LAST 30 DAYS (ALL MODELS)				
2. FLIGHT TIME LAST 2½ HOURS (ALL MODELS)				
3. NUMBER OF FLIGHTS LAST 2½ HRS (INCLUDE PRESENT FLIGHT)				
4. TIME AT CONTROLS THIS FLIGHT				
5. TOTAL FLIGHT TIME ALL MODELS				
FLIGHT TIME THIS MODEL	6. TOTAL	LAST 7. 30	8. 60	9. 90 DAYS
10. NO. GROUNDBINGS PAST YEAR				
11. NO. DAYS GROUNDED PAST YEAR				
12. DATE AND TYPE OF PRIOR MISHAPS				
See MOR 4-63, VF-96				
13. NO. HOURS IN A DUTY STATUS LAST 2½ HOURS				
14. DIRECTION FACING AT TIME OF MISHAP.				
15. LOCATION AT TIME OF MISHAP.				

## 16. "LABORATORY TESTS AND RESULTS"

SPECIMEN	TEST PERFORMED	RESULTS	SPECIMEN	TEST PERFORMED	RESULTS
BLOOD: 1.			TISSUE: (CNS)		
2.			MUSCLE		
3.			VISCERA		
URINE:			OTHER:		
C.S.F. CONTENT					

## 17. X-RAY RESULTS

RRN NO.	MODEL A/C	BUNO	IDENTIFICATION OF INDIVIDUAL		
1-63	F4B	118 391	LTJG [REDACTED]	(b) (6)	VP-96

SPECIAL HANDLING REQUIRED

## SECTION A

FACTORS CONTRIBUTING TO OR RELATING TO MISHAP BY PHASE OF MISHAP  
(LIST IN ORDER, IN ACCORDANCE WITH SECTION B OF INSTRUCTION)

1. FACTORS	2. * PHASE OF MISHAP				*PHASE CODE	A-ACCIDENT S-SURVIVAL	E-ESCAPE/EGRESS R-RESCUE
	A	E	S	R			
1. Poor judgement	C	N/A	N/A	N/A			
2. Weather	C	N/A	N/A	N/A			
3. Tempo of operations	C	N/A	N/A	N/A			

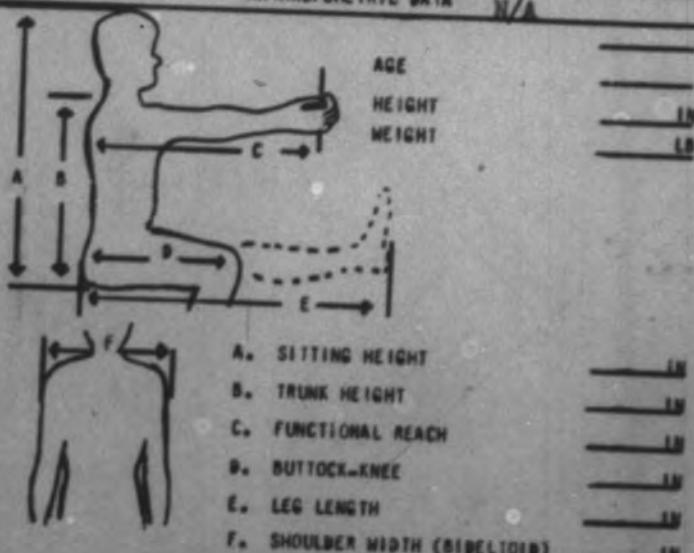
1. Tower allowed short interval landing at night, mostly due to # 2 and 3.  
 In addition, Tower allowed aircraft ST602 to remain in the pattern with inadequate lighting (for 3 passes).

Tower delayed too long in terminating MLP. Under existing weather conditions, Tower was unable to see the planes in the pattern.

## SECTION C AIR CREW DATA N/A

1. FLIGHT TIME LAST 30 DAYS (ALL MODELS)				
2. FLIGHT TIME LAST 2½ HOURS (ALL MODELS)				
3. NUMBER OF FLIGHTS LAST 2½HRS (INCLUDE PRESENT FLIGHT)				
4. TIME AT CONTROLS THIS FLIGHT				
5. TOTAL FLIGHT TIME ALL MODELS				
FLIGHT TIME THIS MODEL	6. TOTAL	LAST 7. 30	8. 60	9. 90 DAYS
10. NO. GROUNDBINGS PAST YEAR				
11. NO. DAYS GROUNDED PAST YEAR				
12. DATE AND TYPE OF PRIOR MISHAPS				
13. NO. HOURS IN A DUTY STATUS LAST 2½ HOURS				
14. DIRECTION FACING AT TIME OF MISHAP				
15. LOCATION AT TIME OF MISHAP				
16.	"LABORATORY TESTS AND RESULTS"			

## SECTION D ANTHROPOMETRIC DATA N/A



(COMPARE WITH HEALTH RECORD)

SPECIMEN	TEST PERFORMED	RESULTS	SPECIMEN	TEST PERFORMED	RESULTS
BLOOD 1.			TISSUE: (CNS)		
2.			MUSCLE		
3.			VISCERA		
URINE:			OTHERS:		
G.I. CONTENT					
17. X-RAY RESULTS					

ITEM NO.	MODEL A/C	BOARD	IDENTIFICATION OF INDIVIDUAL
1-63	F4B	148 391	TOWER, NAS MIRAMAR

## SECTION J

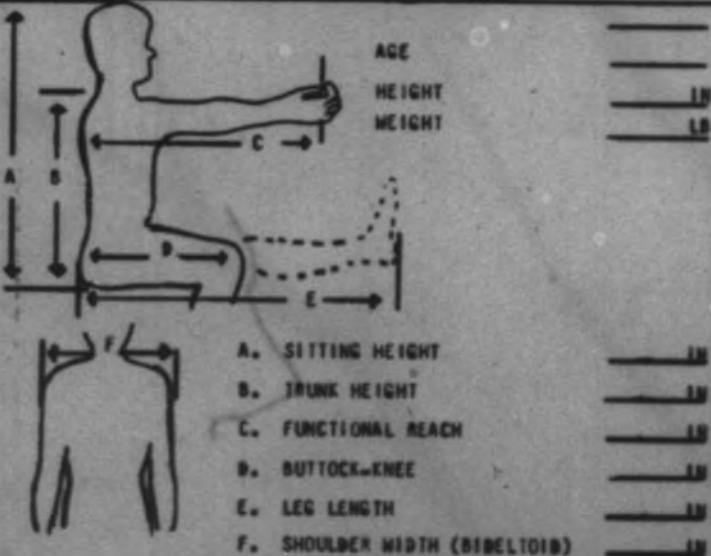
FACTORS CONTRIBUTING TO OR RELATED TO MISHAP BY PHASE OF MISHAP.  
(LIST IN ORDER, IN ACCORDANCE WITH SECTION B OF INSTRUCTION)

1. FACTORS	2. * PHASE OF MISHAP				*PHASE CODE	A-ACCIDENT	E-ESCAPE/EGRESS
	A	E	S	R	FACTOR WEIGHT	S-SURVIVAL	R-RESCUE
	C-CONTRIBUTING Q-QUESTIONABLE OR POSSIBLE						
Disobedience	O	N/A	N/A	N/A			

## SECTION C AIR CREW DATA N/A

1. FLIGHT TIME LAST 30 DAYS (ALL MODELS)				
2. FLIGHT TIME LAST 2½ HOURS (ALL MODELS)				
3. NUMBER OF FLIGHTS LAST 2½ HOURS (INCLUDE PRESENT FLIGHT)				
4. TIME AT CONTROLS THIS FLIGHT				
5. TOTAL FLIGHT TIME ALL MODELS				
FLIGHT TIME THIS MODEL	6. TOTAL	LAST 30	8. 60	9. 90 DAYS
10. NO. GROUNDBINGS PAST YEAR				
11. NO. DAYS GROUNDED PAST YEAR				
12. DATE AND TYPE OF PRIOR MISHAPS				
13. NO. HOURS IN A DUTY STATUS LAST 2½ HOURS				
14. DIRECTION FACING AT TIME OF MISHAP.				
15. LOCATION AT TIME OF MISHAP.				

## SECTION B ANTHROPOMETRIC DATA N/A



(COMPARE WITH HEALTH RECORD)

## 16. LABORATORY TESTS AND RESULTS N/A

SPECIMEN	TEST PERFORMED	RESULTS	SPECIMEN	TEST PERFORMED	RESULTS
BLOOD 1.			TISSUE: (CHS)		
2.			MUSCLE		
3.			VISCERA		
URINES:			OTHERS		
C.I. CONTENT					

## 17. X-RAY RESULTS

NO. 1409	MODEL NO/C Fu-B	SDNO 148391	IDENTIFICATION OF INDIVIDUAL ISO, NAS MIRAMAR
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MEDICAL OFFICER'S REPORT  
OP-10 FORM 7720-88 (REV 1-63)

SECTION E

SPECIAL HANDLING REQUIREMENTS

USE SECTION E OF INSTRUCTION: TO BE COMPLETED ON PLANE COMMANDER, PILOT, CO-PILOT, OTHER INDIVIDUAL IN CONTROL OF AIRCRAFT; TIME OF MISCHAP, AND/OR INDIVIDUAL CAUSING THE MISCHAP.

USE LOCAL TIME AND RECORD TO THE RIGHT OF EACH COLUMN.

16 HRS PRIOR TO MISCHAP

INDIVIDUAL CHRONOLOGICAL DATA

8-10-6  
1400- Rested at Home  
1800- Dinner  
1900- 2000- Entertained visitors  
2300- To bed - goodnight's rest

8-11-6  
0800- Awoke, had breakfast  
0900- 1000- Light work in yard  
1200- Lunch  
1200- 1400- Worked in yard; rested indoors  
1300- Dined out with wife and children  
2000- Returned home, watched T.V.  
2200- To bed - good night's rest

2129-  
2129-  
180° position - ST602 in sight at 90° point.  
LF406 asked by tower if possible to land  
on 2LR. When tower notified that this was  
not possible, LF406 was cleared to land on  
2LR. LF406 lost sight of ST602. Then  
LF406 thought he saw ST602 crossing thresh-  
old on right side of 2LR.  
Lineup on left side 2LR. Touchdown.

Hears ST602 request turnoff at 10,000 feet.  
tower says negative to request and advises  
ST602 that LF406 is close behind. 406  
receives warning that 602 is ahead. LF406  
sees silhouette of ST602 ahead and begins  
heavy right braking  
Contact and shutdown on runway.

ESCAPE PHASE	ACCIDENT PHASE
Not applicable	

2131

0600- Awoke - good breakfast  
0745- Sickbay, NAS Miramar  
0900- Flight physical - put in an up status  
1000- 1100- Had runt at BOQ - read in lobby  
of BOQ  
1130- Arrived at squadron ready room  
1230- Lunch at BOQ  
1330- Returned to squadron ready room -  
did paperwork  
1430- 1530- Refresher MLP hop in FLB-performed  
6-7 FMLP  
1630- Relaxed at squadron ready room, paperwork  
1800- Dinner at BOQ  
1900- Returned to squadron ready room - relaxed  
and then attended briefing  
2000- Manned aircraft  
2030- Taxied to runway - awarded weather clearance  
climb to altitude. Orbited at high power  
until ...  
2100- Commenced TACAN approach to a GCA low  
approach for a VFR entry downwind  
2120- Cleared downwind for entry into MLP  
2125- Entered downwind for MLP  
2128 MLP touchdown and takeoff - Switched to  
tower frequency for final landing clearance  
as requested by tower. Entered downwind  
behind ST602

SURVIVAL

Not applicable

REF 3

NAME	GRADE	BU#	TRANSMITTER OR RECEIVER
L-63	FLB	118 391	(b) (6)

NAME OF INDIVIDUAL

SECTION I DETAILS OF ESCAPE/EGRESS/SURVIVAL PHASES			(REFER TO SECTION I OF INSTRUCTIONS)		
1. TOPOGRAPHY OF IMMEDIATELY'S LANDING SITE <input type="checkbox"/> WATER <input type="checkbox"/> LAND <input type="checkbox"/> OTHER N/A					
2. TYPE OF EGRESS <input type="checkbox"/> EJECTION <input type="checkbox"/> BAILOUT <input checked="" type="checkbox"/> UNDERWATER <input type="checkbox"/> NORMAL <input type="checkbox"/> OTHER (STATE TYPE) N/A					
B	E	REMARKS			
		3. NOT ATTEMPTED			
		4. ATTEMPTED			
		5. ACCOMPLISHED			
		6. THRU CANOPY			
YES	NO	EGRESS DIFFICULTIES		17. YES, EXPLAIN DIFFICULTIES	
		7. PRIOR TO EGRESS			
		8. DURING EGRESS			
		9. SUBSEQUENT TO EGRESS			
10. TYPE AND MODE OF EJECTION SEAT USED.			11. METHOD OF FIXING SEAT <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY <input type="checkbox"/> OTHER		12. DURATION OF EJECTION
13. POSITION OF SEAT ON EJECTION UP <input type="checkbox"/> DOWN <input type="checkbox"/> FORWARD <input type="checkbox"/> AFT <input type="checkbox"/> OTHER			14. ALTITUDE OR WAKEOVER OF A/C AT EXIT. 15. AIR SPEED		
16. ALTITUDE AT TIME OF EXIT (FEET) ABOVE SEA LEVEL			17. ALTITUDE OF PARACHUTE OPENING		18. METERS
19. TIME IN WATER			20. TIME IN RAFT		21. WIND VELOCITY
22. WAVE HEIGHT			23. WATER TEMPERATURE		24. VISIBILITY
25. ALERTING FACTORS			26.		27.
28. REASONS OF LOCATING ACCIDENT SITE			29.		30.
31. REASONS OF LOCATING SURVIVOR			32.		33.
34. DID INDIVIDUAL DEPART FROM LANDING SITE? _____			18. YES, EXPLAIN REASONS AND SOURCE OF INFORMATION		

SECTION II TRAINING FACTORS		
1. DATE OF LAST TRAINING. LPC 12 DEC 60 EJECTION TIME UNKNOWN EJECTION SEAT 6 DEC 60 SURVIVAL UNKNOWN		
2. DID THE LACK OF TRAINING AND/OR EXPERIENCE PLAY A PART IN ANY PHASE OF THIS RESCUE? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES, EXPLAIN		

ITEM NO.	MODEL X/Y	TYPE	CHIEF
1-63	74B	118 391	(b) (6)

NAME OF SURVIVOR

Addendum, MOR, VF-114, 1-6, Cdr. (b) (6)

On 22 JUL 63 Ddr. (b) (6) was admitted to USNH San Diego with (b) (6)  
(b) (6) (b) (6). He had complained of (b) (6)

Extensive physical examination and laboratory studies were all within normal limits, and Cdr. (b) (6) was discharged, fit for full duty, on 9 Aug 63 with the diagnosis: Observation, medical. By this time he had had complete remission of his symptoms and (b) (6). During hospitalization, Cdr. (b) (6) was up and about and was allowed frequent liberty.

Unfortunately, this observer had not met Cdr. (b) (6) prior to 0800 12 Aug 63, when Cdr. (b) (6) was examined for clearance for flying by Lt. (b) (6) (MC) USNR, whom I was relieving. Dr. (b) (6) felt at that time that Cdr. (b) (6) was fit for full duty including flying, and cleared him for same.

During that day, Cdr. (b) (6) flew two hops:

- a) a 1.8 hour refresher hop that afternoon (see, MOR pg. 3).
- b) a 0.8 hour hop, at termination of which the accident occurred.

The thought of fatigue as a causative factor enters here. Having just returned from three weeks' hospitalization for (b) (6) and flying two hops totalling 2.6 hours may have been too strenuous for the first day back to duty. Fatigue was strongly considered at the inception of the investigation, and the following information garnered:

1) Cdr. (b) (6) did little else on 12 Aug 63 besides fly and rest (see, MOR pg. 3). Cdr. (b) (6) has stated that he felt alert and well-rested prior to and during the flight.

2) He was noted by his RIO and the other pilots to appear alert and not the victim of fatigue, although some of his co-workers have noted that he still hadn't attained his former picture of full health.

3) Lt. (b) (6) the RIO, noted no difficulty at all during either of the two hops, and commented favorably on his steadiness during both flights. The FMLP performed just prior to the final touchdown and subsequent accident was considered smooth by the pilot, the RIO and the LSO.

4) Cdr. (b) (6) had been given full clearance for duty involving flying by the three physicians who followed him closely during his illness. These same physicians have also stated that Cdr. (b) (6) physical state on 12 Aug 63 did not appear to be of a contributory nature to the accident.

On the basis of the information gathered, it is our distinct impression that pilot fatigue played a very small role, if any, in this accident.

Very respectfully,

(b) (6)  
Lt. (MC) USNR

Addendum:

Since 12 Aug 63 Cdr. (b) (6) has been closely followed by me. He has continued to gain weight and experience good health as well as perform his regular duties as Executive Officer of VF-114. He has continued in a flying status which involves day and night carrier operations and has performed well and without difficulty.

(b) (6)

Lt. (MC) USNR

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT - PAGE 1  
 OPNAV FORM 3750-8 (REV. 5-56) OPNAV REPORT 3750-7  
See OPNAVINST. 3750.6C for instructions - SPECIAL HANDLING REQUIRED

SECTION A - IDENTIFICATION

1. FROM (Name and mailing address of activity) <b>FIGHTER SQUADRON NINETY SIX, NAS, MIRAMAR, CALIFORNIA</b>				2. MOR NUMBER <b>I-63A</b>	
(b) (6)		Signature of Medical Officer		DATE	4. FORWARDER/NA
LT MC USN				22 Aug 63	(b) (6)
5. TYPE OF MISHAP <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> GROUND ACCIDENT <input type="checkbox"/> INCIDENT.		6. TIME AND ZONE <b>2130 T</b>		7. DATE <b>12 Aug 63</b>	8. GEOGRAPHICAL LOCATION <b>On Runway at NAS, MIRAMAR, CALIF.</b>
9. MODEL A/C <b>F4B</b>		10. BUNO <b>150645</b>	11. NO. OF OCCUPANTS <b>2</b>	12. TYPE ACCDT. <b>A/2</b>	13. DAMAGE CODE <b>B</b>
14. UNIT OPERATING A/C <b>VF-96</b>		15. IN CONTROL OF A/C <b>(b) (6)</b>		16. UNIT TO WHICH ATTACHED <b>VF-96</b>	17. RANK RATE <b>LT JG</b>
18. FILE/SERV. NO. DESIGNATOR <b>(b) (6)</b>		19. BILLET <b>Pilot</b>		20. BRANCH OF SERVICE <b>USN</b>	21. INJURY CODE <b>G</b>
22. NAME (Last, first and middle initials) <b>b. (b) (6)</b>		23. CLARIFICATION OF ITEMS 15-22 WHEN NECESSARY <b>VF-96</b>		24. NAO(I) <b>NAO(I)</b>	25. DISPOSITION <b>I</b>
24. MODEL - OTHER A/C IF INVOLVED <b>F4B</b>		25. BUNO <b>148391</b>	26. NO. OF OCCUPANTS <b>2</b>	27. UNIT OPERATING A/C <b>VF-114</b>	28. DAMAGE CODE <b>B</b>
29. REPORT NO. <b>I-63A</b>					
30. DETAILED NARRATIVE ACCOUNT OF ACCIDENT (Use additional 8 X 10½ plain sheets if required.)  See MOR for VF-114(I-63A)					

SECTION B - MEDICAL OFFICER'S QUESTIONNAIRE

(If "NO" state reason in space below.)

YES	NO	DID THE FLIGHT SURGEON:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. VISIT THE SCENE OF THE MISHAP?  Was not notified of accident at time of occurrence
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. PARTICIPATE FULLY IN THE FIELD INVESTIGATION?  Same as above
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. PARTICIPATE FULLY IN THE DELIBERATIONS OF THE A/C ACCIDENT BOARD?  VF-114 deployed aboard USS <b>Kitty Hawk</b>

GIVE APPROXIMATE NUMBER OF HOURS SPENT BY THE FLIGHT SURGEON:  
**100**

4. IN FIELD INVESTIGATION    5. IN BOARD DELIBERATIONS    6. IN PREPARATION OF THIS REPORT

7. REPORT PREPARATION CHECK LIST  
 ALL PARTS OF FORM COMPLETED     SURVIVORS NARRATIVES     PHOTOS     CONCLUSIONS AND RECOMMENDATIONS     REQUIRED COPIES FURNISHED

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 70, OPNAV INST 3750.6D

GOVERNMENT PRINTING OFFICE : 1640-942299

**MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT—Page 2**

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OPNAV REPORT 3750-7

**SECTION C—PHYSIOLOGICAL, HUMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL, AND TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT**

NAME OF INDIVIDUAL (Last, first, middle)

MODEL A/C

(b) (6)

F4B

Check E-established, S-suspected, or P-Present for each factor selected. Additional 8X10½ plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., C1, C2, etc.). Attach all sheets pertaining to these factors to this form upon completion.

E	S	P	✓ FACTORS	E	S	P	✓ FACTORS
<b>PHYSIOLOGICAL:</b>							
			1. Physically incapacitated in flight				29. Expeditions/Delays
			2. "G" forces				30. Weather
			3. Environmental stress - External				31. Mechanical Problems
			4. - Internal				32. Social and working relationships
			5. Dysbarism/explosive decompression				33. Personal comfort
			6. Diet				34. Regulations
			7. Fatigue				35. Facilities
			8. Hypoxia				36. Navigation
			9. Related illness				37. Duty assignment
			10. Vertigo/Disorientation/Illusions				38. Personality traits
			11. Hyperventilation				<b>NON-STRESS FACTORS:</b>
			12. Drugs				39. Faulty attention
			13. Physical state				40. Poor judgement
			14. OTHER:				41. Forgetfulness
<b>HUMAN ENGINEERING AND DESIGN:</b>							
			15. Personal equipment				42. OTHER SOCIO-PSYCHOLOGICAL FACTORS
			16. Displays and/or controls				
			17. Work arrangement				
			18. Working environment				
			19. Habit interference				
			20. OTHER:				
<b>SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources)</b>							
			21. Pregnancy				<b>TRAINING FACTORS:</b>
			22. Illness or death				43. Physiological training
			23. Arguments				44. Emergency Procedures training
			24. Elated/Depressed state				45. Survival and rescue training
			25. Personal habits - Drinking				46. Refresher training
			26. - Sex				47. Transition training
			27. - Gambling				48. OTHER:
			28. - Debts				

**SECTION D — AIR CREW DATA** (fill in where applicable)

1. Flight time past 30 days	33.3	7. Total time in model	355.5
2. Flight time last 24 hours	0.0	8. Number of days grounded last month, give reason	None
3. Number of flights in last 24 hours	1	9. Number of and dates of previous accidents	None
4. Time at controls this flight	1.6		
5. Number of hours duty last 24 hours	8.0		
6. Total flight time	667.2		

**SECTION E — CONTRIBUTING FACTORS AND THEIR ANALYSIS** (As condensed from Part I, Sect. D and Part VIII of the ARR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, i.e. 15(a). Attach additional sheets as necessary.

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT - PAGE 3  
OPNAV FORM 3750-BB (5-58)

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SECTION F - SAFETY, PERSONAL, AND SURVIVAL EQUIPMENT

Prepare a narrative account of damaged or failed items. Identify each item discussed (e.g., F1, F2, etc.)

NAME OF INDIVIDUAL (Last, first, middle)

(b) (6)

MODEL A/C  
F4B

GENERAL DESCRIPTION OF EQUIPMENT	AVAIL-ABLE		SPECIFIC MODEL OR TYPE	UTILIZED		FAILED		DESCRIPTION OF DAMAGE TO EQUIPMENT
	YES	NO		YES	NO	YES	NO	
1. Shoulder harness	X		Martin Baker	X		X		
2. Lap belt	X		Martin Baker	X		X		
3. Inertia reel	X		Martin Baker	X		X		
4. G-Suit Harness	X		Z-3 Cutaway	X		X		
5. Pressure suit-full or partial	X				X			
6. Exposure suit	X		Summer Orange	X		X		
7. Flight suit (Other than above)	X		APH-5	X		X		
8. Helmet	X		APH-5	X				
9. Goggles/Eyeshield	X		APH-5		X			
10. Shoes	X		Iron Age	X		X		
11. Gloves	X		Summer Flying	X		X		
12. Life vest	X		MK-3C		X			
13. Life raft	X		PK-2		X			
14. OTHER: Seat Pan	X		Scott Pan F4B-1	X				
Pistol	X		SW 38 cal.	X				
15. SIGNAL DEVICE - Flare (Night)	X		MK-13 Mod 0	X				
16. - Flare (Day)	X		MK 13, Mod 0	X				
17. - Dye marker	X		Standard	X				
18. - Radio	X							
19. - Flashlight	X		D-31		X			
20. - Mirror	X		Signal		X			
21. OTHER:								
22. SURVIVAL GEAR - Knife	X		Sheath and shroud	X				
23. - First aid kit	X		PSK-2	X				
24. - Shelter								
25. - Food	X		IA food packet	X				
26. OTHER:								
27. RESCUE - Vehicle								
28. - Sling, Net, Stretcher								
29. OTHER:								

SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE

1. MASK - MODEL OR TYPE <b>A-13-A</b>		2. MODIFICATIONS, IF ANY <b>None</b>		7. LIST DISCREPANCIES NOTED BY PREFLIGHT CHECK <b>None</b>			
3. REGULATOR - MODEL OR TYPE <b>Bendix 29211-CI</b>		4. MODIFICATIONS, IF ANY <b>None</b>		8. WAS OXYGEN IN USE AT TIME OF ACCDT. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
5. PREFLIGHTED BY USER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		6. IF NO, WHY NOT		9. TIME OF ACCIDENT Unknown			
8. OXYGEN SUPPLY: <b>9.5</b> LITERS (Liquid) _____ P.S.I. (Gas) _____		10. IF YES, WAS SELECTOR SETTING <b>100%</b> NORMAL		11. WAS ALL OXYGEN EQUIPMENT NECESSARY FOR THIS FLIGHT AVAILABLE? IF NO, LIST ITEMS AND REASON WHY. <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12. WAS OXYGEN MASK REMOVED AT ANY TIME IN FLIGHT? IF YES, GIVE DURATION AND REASON. <b>NO</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/>	
13. TYPE CHUTE RELEASE DEVICE <b>Martin Baker</b>		14. TYPE HARNESS RELEASE DEVICE <b>Martin Baker</b>		15. WHEN WERE RELEASE DEVICES ACTIVATED? <b>N.A.</b>			
16. WERE DIFFICULTIES ENCOUNTERED WITH RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
17. WERE DIFFICULTIES ENCOUNTERED AFTER ACTIVATING RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
18. WAS LIFE VEST INFLATED PRIOR TO ACTIVATING RELEASE DEVICES? IF YES, WHAT DIFFICULTIES DID THIS PRODUCE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 70, OPNAV INST 3750.6D

## SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE (Cont'd.)

(b) (6)

MODEL A/C

F-4B

RESTRAINT HARNESS	19. INTEGRATED HARNESS SYSTEM, MODEL/TYPE <b>Martin Baker 5</b>	20. INTEGRATED: <input checked="" type="checkbox"/> FULL <input type="checkbox"/> PARTIAL	21. MODIFICATIONS, IF ANY STATE REASON <b>None</b>
	22. DID INTEGRATED HARNESS FIT PROPERLY? IF NO, LIST DISCREPANCIES IN FIT AND GIVE REASONS THEREFOR <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		
HELMET	23. INTEGRATED HARNESS FITTING WAS CONDUCTED BY: <input checked="" type="checkbox"/> WEARER <input type="checkbox"/> FLIGHT SURGEON <input checked="" type="checkbox"/> PARACHUTE RIGGER <input type="checkbox"/> AVIATION EQUIPMENT OFFICER <input type="checkbox"/> OTHER		
	24. IF SHOULDER HARNESS WAS USED, WAS IT: <input checked="" type="checkbox"/> LOCKED <input type="checkbox"/> UNLOCKED <input checked="" type="checkbox"/> TIGHT <input type="checkbox"/> BLACK <input type="checkbox"/> OTHER CONDITION		
PARACHUTE	25. TYPE HELMET <b>Navy APH-5</b>	26. LIST PRESCRIBED MODIFICATIONS <b>BACSEBS: 13-57 Nape Strap, 19-59 Button and Visor; Housing assembly.</b>	Hardman Fittings
	27. OTHER MODIFICATIONS AND REASON FOR THEM <b>None</b>		
OTHER	28. DID HELMET FIT PROPERLY? IF NO, GIVE REASON <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
	29. HELMET FITTING WAS CONDUCTED BY: <input checked="" type="checkbox"/> WEARER <input type="checkbox"/> FLIGHT SURGEON <input checked="" type="checkbox"/> PARACHUTE RIGGER <input type="checkbox"/> AVIATION EQUIPMENT OFFICER <input type="checkbox"/> OTHER		
30. TYPE CHUTE		31. LAST PACKING DATE	32. MODEL/TYPE BAILOUT OXYGEN
		33. AUTOMATIC RIPCORD, IF INSTALLED (Model and type) <input type="checkbox"/> NONE	
34. DID AUTOMATIC RIPCORD FAIL? IF YES, WHY? <input type="checkbox"/> NO		35. WAS RIPCORD ACTIVATION <input type="checkbox"/> MANUAL <input type="checkbox"/> AUTOMATIC	
36. IF MANUALLY ACTIVATED STATE REASON AND ANY DIFFICULTIES ENCOUNTERED			
37. DID CHUTE OPEN IMMEDIATELY? IF NO, GIVE REASON <input type="checkbox"/> YES <input type="checkbox"/> NO			
38. ALTITUDE THAT CHUTE OPENED FEET			
39. OPENING SHOCK WAS: <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE		40. BODY ATTITUDE AT OPENING	
41. CONDITION OF CHUTE AFTER OPENING		42. CHUTE OSCILLATION PRESENT: <input type="checkbox"/> NONE <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE	
43. IF OSCILLATION WAS PRESENT, HOW WAS IT STOPPED?		44. WEATHER CONDITIONS DURING DESCENT (List in sequence)	
45. TOPOGRAPHY OF LANDING SITE		46. WAS BAILOUT OXYGEN CONNECTED? BEFORE EXIT <input type="checkbox"/> AFTER EXIT <input type="checkbox"/> NO <input type="checkbox"/> N.A. <input type="checkbox"/> YES <input type="checkbox"/> NO	
47. WAS BAILOUT OXYGEN USED? IF NOT, WHY?		48. WHEN WAS IT ACTIVATED? BEFORE EXIT <input type="checkbox"/> AFTER EXIT	
49. GIVE DIFFICULTIES ENCOUNTERED WITH BAILOUT OXYGEN AND THEIR CAUSE, IF ANY		50. WAS CHUTE HARNESS <input type="checkbox"/> TIGHT <input type="checkbox"/> SNUG <input type="checkbox"/> LOOSE	
51. WAS A SITTING POSITION IN SLING OBTAINED DURING DESCENT? IF NOT, WHY? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT ATTEMPTED		52. SEAT CUSHION IF PROVIDED (Model/Type) <input type="checkbox"/> NONE	
53. WAS PARACHUTE LANYARD CONNECTED TO LIFE VEST D RING? IF NOT, WHY? <input type="checkbox"/> NO <input type="checkbox"/> YES		54. LIST TYPE OF PARACHUTE TRAINING COMPLETED BY THIS INDIVIDUAL <input type="checkbox"/> NONE	
55. IF ATTEMPT WAS MADE TO RELEASE PARACHUTE DURING DESCENT, WAS RELEASE ACTIVATED SUCCESSFULLY? <input type="checkbox"/> YES <input type="checkbox"/> NO		56. IF NO, GIVE REASON	
57. IF G-SUIT, EXPOSURE SUIT, FULL OR PARTIAL PRESSURE SUIT WAS WORN, DID IT FIT PROPERLY? IF NOT, LIST DISCREPANCIES IN FIT AND GIVE REASONS THEREFOR <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
58. WAS G-SUIT EQUIPPED WITH A SPRING-LOADED DISCONNECT ADAPTER? IF NO, GIVE REASON <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
59. LIST ALL ITEMS OF NON-STANDARD CLOTHING OR SURVIVAL EQUIPMENT UTILIZED <b>None</b>			
60. IS ANY ITEM OF EQUIPMENT LOST? IF YES STATE ITEM, WHEN LOST, AND REASON FOR LOSS. <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		61. WAS ANY ITEM OF EQUIPMENT DISCARDED? IF YES, STATE ITEM, WHEN DISCARDED, AND REASON FOR DISCARD. <input type="checkbox"/> NO <input type="checkbox"/> YES	

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT - PAGE 5  
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OPNAV REPORT 3750-8

## SECTION H - EMERGENCY EXIT FROM A/C AND SURVIVAL FACTORS

NAME OF INDIVIDUAL (Last, First, Middle)

(b) (6)

MODEL A/C  
F-4B

S	E	S-SUSPECTED, E-ESTABLISHED	REMARKS
1.	EJECTION	- Attempted	
2.		- Accomplished	
3.		- Through canopy	
YES	NO	EJECTION DIFFICULTIES ENCOUNTERED	IF YES, EXPLAIN DIFFICULTIES
4.		- Prior to	
5.		- During	
6.		- Subsequent to	
7. Give type and model of seat used			
8. BAILOUT - Attempted			
- Accomplished			
9. ALTITUDE AT TIME OF EXIT (feet)			
On runway			
ABOVE SEA LEVEL ABOVE TOPOGRAPHY			
12. COLLISION OF A/C WITH		13. CONTROLLED?	
<input type="checkbox"/> GROUND	<input type="checkbox"/> WATER	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	14. POWER <input checked="" type="checkbox"/> ON <input type="checkbox"/> OFF
17. CANOPY POSITION AT EXIT OR IMPACT		18. SEA STATE	19. AIR TEMP. <input type="checkbox"/> 20. WATER TEMP. <input type="checkbox"/> 21. A/C FLOATED <input type="checkbox"/>
<input type="checkbox"/> OPEN	<input checked="" type="checkbox"/> CLOSED <input type="checkbox"/> JETTISONED		22. TIME IN WATER <input type="checkbox"/> 23. TIME IN RAFT <input type="checkbox"/>
24. EXIT USED		25. IS THIS THE RECOMMENDED EXIT? IF NO STATE REASON FOR CHOICE	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	
26. DIFFICULTIES WITH THIS EXIT WERE		27. STATE NATURE OF DIFFICULTY	
<input type="checkbox"/> IN REACHING <input type="checkbox"/> IN OPENING <input type="checkbox"/> IN EXITING			
28. BODY POSITION DURING EXIT			
29. LIST OTHER FACTORS NOT INDICATED ABOVE WHICH Affected EXIT FROM A/C			

SURVIVAL FACTORS Check factors below which are appropriate for this accident. Prepare a detailed narrative account of the factors checked below and attach to this form. Identify each item discussed by Item number (e.g., H30, H31, etc.)

COMMUNICATIONS:		Maintaining Body Temperature:
30. Communicated position prior to mishap		50. Items used as shelter
<input checked="" type="checkbox"/> 31. Witnesses at scene		51. Items used as clothing
32. Electronic signal devices		52. Fire
33. Visual signal devices		53. OTHER:
34. Auditory signal devices		ENVIRONMENTAL HAZARDS:
35. OTHER:		54. Exposure to natural forces
TRAVEL:		55. Exposure to dangerous animals and plants
36. LAND		56. Unfriendly native population
37. WATER		57. OTHER:
SHELTER:		MORALE:
38. Life raft		58. Isolation
39. Parachute		59. Psychological shock
40. A/C structure		60. Lack of motivation to survive
41. Natural shelter		61. Boredom
42. Man-made shelter		62. Rationing, activities, and group coordination
43. OTHER:		63. OTHER:
WATER SOURCE:		FOOD SOURCE:
44. Desalter kit, seawater or solar still		64. Prepared survival rations
45. Rain, dew, snow, ice, etc.		65. Animals/plants
46. Processed beverages		66. OTHER:
47. Canteen, thermos, water breaker, etc.		SURVIVAL TRAINING RECEIVED PRIOR TO MISHAP:
48. Streams, ponds, wells, etc.		67.
49. OTHER:		

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70, OPNAV INST 3750.6D

PRINTING OFFICE: 1002-00004

ADDENDUM TO Page 5, Item #30, MOR 4-63A, VF-96

#30. LTJG (b) (6) had communicated his position on the runway just prior to this mishap. He asked for clearance at the 10 mark taxiway but was told by Control Tower to continue straight ahead due to another F4B rolling behind.

SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 70, OPNAV INST 3750.6D

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT — PAGE 6 OPNAV REPORT 3750.7  
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SECTION 1 - PATHOLOGICAL FACTORS (Use A to denote ANTE MORTEM; P for POST MORTEM, when known and applicable.)

MODEL A/C

F-4B

1. NAME OF INDIVIDUAL (Last, first, middle)

(b) (6)

2. AGE	3. HEIGHT	4. WEIGHT	5. LOCATION AND DIRECTION FACING AT TIME OF ACCIDENT		6. INJURY CODE								
24	(b) (6) INCHES	(b) (6)	Forward in cockpit		E								
7. UNCONSCIOUSNESS			8. INTERNAL INJURIES (Non-fatal cases)										
<input type="checkbox"/> SHORT DURATION <input type="checkbox"/> OTHER (give time) <input type="checkbox"/> LITTLE SIGNIFICANCE			9. FACIAL INJURIES (N. & C.)		10. INTRA-ORAL INJURIES								
HEAD INJURIES	<input type="checkbox"/> MINOR <input type="checkbox"/> SERIOUS <input type="checkbox"/> CRITICAL <input type="checkbox"/> FATAL			11. MAJOR EYE INJURIES									
	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT			<input type="checkbox"/> RIGHT		<input type="checkbox"/> LEFT							
12. MINOR EYE INJURIES													
13. TYPE OF FRACTURE	SKULL	VERTEBRAE (Specify No.)			SHOULDER GIRDLE	RIBS	PELVIS	UPPER ARM	LOWER ARM	HAND	UPPER LEG	LOWER LEG	FOOT
SIMPLE	CRAN.	FACIAL	CERV.	HOR.	LUMBAR	SACRAL	COCCYX	N L	R L	R L	N L	R L	N L
COMPOUND													
COMMINUTED													
DIS-LOCATION	JAW							SHOULDER	ELBOW	WRIST	HIP	KNEE	ANKLE
										HAND			FOOT
14. AMPUTATIONS/AVULSIONS (State Parts)	15. LIST PRE-EXISTING PHYSICAL DEFECTS PRESENT AT TIME OF POST CRASH EXAMINATION												
	None												

17. SOFT TISSUE INJURIES	LACERATIONS			CONTUSIONS/SPRAIN/STRAIN			ABRASIONS			18. <input type="checkbox"/> DROWNED	
	MILD	MODERATE	SEVERE	MILD	MODERATE	SEVERE	MILD	MODERATE	SEVERE		
HEAD (N. & C.)	VENTRAL									19. <input type="checkbox"/> ASPHYXIATED	
	DORSAL									20. SHOCK	21. EXPOSURE
NECK										<input type="checkbox"/> MILD	<input type="checkbox"/> MILD
THORAX	VENTRAL									<input type="checkbox"/> MODERATE	<input type="checkbox"/> MODERATE
	DORSAL									<input type="checkbox"/> SEVERE	<input type="checkbox"/> SEVERE
ABDOMEN	VENTRAL										
	DORSAL										
EXTREMITIES	UPPER										
	LOWER										
22. BURNS	DEGREES	1ST	END	3RD	1ST	END	END	1ST	END	END	23. EXTENT OF CARBONIZATION:
	AREA	HEAD(Ventral)	Dorsal	TRUNK(Ventral)	Dorsal	ARMS	LEGS				<input type="checkbox"/> NONE <input type="checkbox"/> COMPLETE
											ARE TISSUE SPECIMENS OBTAINABLE?
											<input type="checkbox"/> YES <input type="checkbox"/> NO
24. FROST BITE											

NOTE: Attach a detailed narrative account of injuries, cause, structures causing injury, magnitudes of force, and include whether ANTE-OR POST-MORTEM if determined. It is necessary to give as clear a picture of injury cause and sequence as possible.

25. ADMITTED TO SICK LIST? IF YES, GIVE DIAGNOSE

YES       NO

26. DIAGNOSIS NO. (NAVMED P-1294)

27. ESTIMATED STAY ON SICK LIST

DAYS

27. GROUNDED? IF YES GIVE REASON

YES       NO

28. ESTIMATED DURATION

DAYS

29. PRIMARY CAUSE OF DEATH (Use Basic Diagnostic Nomenclature, NAVMED P-1294)

30. SECONDARY CAUSE OF DEATH

NO.

31. AUTOPSY PERFORMED	32. PROTOCOL	<input type="checkbox"/> ATTACHED	<input type="checkbox"/> WILL BE FORWARDED	33. AUTOPSY CONDUCTED BY	IF FLIGHT SURGEON DOES AUTOPSY, USE "AUTOPSY GUIDE FOR A/C ACCIDENT FATALITIES", AFIP, 1957.	
<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> PATHOLOGIST	<input type="checkbox"/> FLIGHT SURGEON	
34. SPECIMEN	TEST PERFORMED	RESULTS		SPECIMEN	TEST PERFORMED	RESULTS
BLOOD:				TISSUE: (CNS)		
				MUSCLE		
				VISCERA		
URINE				OTHER:		
G-1 CONTENTS						

35. IF ULTRAVIOLET LIGHT OR OTHER SPECIALIZED PROCEDURES WERE USED AT THE KINSHAP SITE OR AUTOPSY, LIST THEM IN THIS SPACE. FOR EACH ENTRY IN THIS SPACE A NARRATIVE ACCOUNT OF THEIR RESULTS AND INTERPRETATION WILL BE ATTACHED.

**MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT—Page 2**

OPNAV FORM 3750-6A (REV. 5-58)

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**SECTION C—PHYSIOLOGICAL, HUMAN ENGINEERING, DESIGN, SOCIO-PsYCHOLOGICAL, AND TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT**

NAME OF INDIVIDUAL: (Last, first, middle) [REDACTED]

(b) (6)

Check E=Established, S=Suspected, or P=Present for each factor selected. Additional 8X10½ plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., C1, C2, etc.). Attach all sheets pertaining to those factors to this form upon completion.

MODEL A/C

P-4B

MA E S P	V FACTORS	E S P	V FACTORS	SOCIO-PSYCHOLOGICAL: (Emotional areas from duty hours)	
				NON-STRESS FACTORS:	STRESS FACTORS:
	1. Physically incapacitated in flight		10. Vertigo/Disorientation/Illusions	38. Personality traits	30. Weather
	2. "G" forces		11. Hyperventilation	39. Facilities	31. Mechanical Problems
	3. Environmental stress - External		12. Drugs	40. Faulty attention	32. Social and working relationships
	4. Internal		13. Physical state	41. Poor judgement	33. Personal comfort
	5. Dysthymia/explosive decompression		14. OTHER:	42. OTHER SOCIO-PSYCHOLOGICAL FACTORS	
	6. Diet				
	7. Fatigue				
	8. Hypoxia				
	9. Related illness				
	15. Personal equipment				
	16. Displays and/or controls				
	17. Work arrangement				
	18. Working environment				
	19. Habit interference				
	20. OTHER:				
	SOCIO-PSYCHOLOGICAL: (Emotional areas from non-duty sources)				
	21. Pregnancy		43. Physiological training		
	22. Illness or death		44. Emergency Procedures training		
	23. Arguments		45. Survival and rescue training		
	24. Elated/Depressed state		46. Refresher training		
	25. Personal habits - Drinking		47. Transition training		
	26. - Sex		48. OTHER:		
	27. - Gambling				
	28. - Debts				

**SECTION D — AIR CREW DATA** (Fill in where applicable)

1. Flight time past 30 days	21.5	7. Total time in model
2. Flight time last 24 hours	1.6	8. Number of days grounded last month, give reason
3. Number of flights in last 24 hours	1	None
4. Time at controls this flight	NA	9. Number of and dates of previous accidents
5. Number of hours duty last 24 hours	8.0	None
6. Total flight time	1835.0	

**SECTION E — CONTRIBUTING FACTORS AND THEIR ANALYSIS** (As condensed from Part I, Sec. D and Part VIII of the AFR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, 1a, 15(a). Attach additional sheets as necessary.

NA

## SECTION F - SAFETY, PERSONAL, AND SURVIVAL EQUIPMENT

Prepare a narrative account of damaged or failed items. Identify each item discussed (e.g., F1, F2, etc.)

NAME OF INDIVIDUAL (Last, first, middle) (b) (6)					MODEL A/C F-4B		
	GENERAL DESCRIPTION OF EQUIPMENT		SPECIFIC MODEL OR TYPE	UTILIZED	FAILED		
	AVAILABLE			YES	NO	YES	NO
1. Shoulder harness	X	Martin Baker		X		X	
2. Lap belt	X	Martin Baker		X		X	
3. Inertia reel	X	Martin Baker		X		X	
4. G-Suit Harness	X	2-3 Cutaway		X		X	
5. Pressure suit-full or partial	X				X		
6. Exposure suit	X	MK-5			X		
7. Flight suit (Other than above)	X	Summer Orange		X		X	
8. Helmet	X	APH-5		X		X	
9. Goggles/Eyeshield	X	APH-5			X		
10. Shoes	X	Iron Age		X		X	
11. Gloves	X	Summer flying		X		X	
12. Life vest	X	MK3-C			X		
13. Life raft	X	PK2			X		
14. OTHER: Seat Pan	X	Scott Pan F4B-1			X		
Pistol	X	S&W .38 Cal.			X		
15. SIGNAL DEVICE - Flare (Night)	X	MK 13 Mod. 0			X		
16. - Flare (Day)	X	MK 13 Mod. 0			X		
17. - Dye marker	X	Standard			X		
18. - Radio	X						
19. - Flashlight	X	D-31			X		
20. - Mirror	X	Signal			X		
21. OTHER:							
22. SURVIVAL GEAR - Knife	X	Sheath & Shroud			X		
23. - First aid kit	X	PSK-2			X		
24. - Shelter	X				X		
25. - Food	X	L A Food Packet			X		
26. OTHER:							
27. RESCUE - Vehicle							
28. - Sling, Net, Stretcher							
29. OTHER:							

## SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE

1. BASE - MODEL OR TYPE <b>A-B-A</b>		2. MODIFICATIONS, IF ANY <b>None</b>				
3. REGULATOR - MODEL OR TYPE <b>Bendix 29211 - C1</b>		4. MODIFICATIONS, IF ANY <b>None</b>				
OXYGEN EQUIPMENT	5. PREFLIGHTED BY USER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	6. IF NO, WHY NOT	7. LIST DISCREPANCIES NOTED BY PREFLIGHT CHECK <b>None</b>			
	6. OXYGEN SUPPLY: <b>9.5 LITERS (Liquid)</b>	7. TIME OF ACCIDENT <b>unknown</b>	8. WAS OXYGEN IN USE AT TIME OF ACCD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
9. IF YES, WAS SELECTOR SETTING <b>100%</b>		10. WAS ALL OXYGEN EQUIPMENT NECESSARY FOR THIS FLIGHT AVAILABLE? IF NO, LIST ITEMS AND REASON WHY. <b>None</b>				
11. WAS OXYGEN MASK REMOVED AT ANY TIME IN FLIGHT? IF YES, GIVE DURATION AND REASON. <b>None</b>		12. WAS LIFE VEST INFLATED PRIOR TO ACTIVATING RELEASE DEVICES? IF YES, WHAT DIFFICULTIES DID THIS PRODUCE? <b>None</b>				
13. TYPE CHUTE RELEASE DEVICE <b>Martin Baker</b>		14. TYPE HARNESS RELEASE DEVICE <b>Martin Baker</b>		15. WHEN WERE RELEASE DEVICES ACTIVATED? <b>N/A</b>		
16. WERE DIFFICULTIES ENCOUNTERED WITH RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. <input type="checkbox"/> YES <input type="checkbox"/> NO						
17. WERE DIFFICULTIES ENCOUNTERED AFTER ACTIVATING RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. <input type="checkbox"/> YES <input type="checkbox"/> NO						
18. WAS LIFE VEST INFLATED PRIOR TO ACTIVATING RELEASE DEVICES? IF YES, WHAT DIFFICULTIES DID THIS PRODUCE? <input type="checkbox"/> YES <input type="checkbox"/> NO						

(Continued on OPNAV FORM 3750-EC)  
SPECIAL HANDLING REQUIRED IN ACCORDANCE  
WITH PARAGRAPH 70, OPNAV INST 3750.6D

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## SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE (Continued)

NAME OF INDIVIDUAL (Last, first, middle) <b>(b) (6)</b>		MODEL A/C <b>F-4B</b>	
RESTRAINT HARNESS	19. INTEGRATED HARNESS SYSTEM, MODEL/TYPE <b>Martin Baker 5</b>	20. INTEGRATED? <input checked="" type="checkbox"/> FULL <input type="checkbox"/> PARTIAL	21. MODIFICATIONS, IF ANY STATE REASON <b>None</b>
	22. DID INTEGRATED HARNESS FIT PROPERLY? IF NO, LIST DISCREPANCIES IN FIT AND GIVE REASONS THEREFOR <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		
HELMET	23. INTEGRATED HARNESS FITTING WAS CONDUCTED BY: <input checked="" type="checkbox"/> WEARER <input type="checkbox"/> FLIGHT SURGEON <input checked="" type="checkbox"/> PARACHUTE RIGGER <input type="checkbox"/> AVIATION EQUIPMENT OFFICER <input type="checkbox"/> OTHER		
	24. IF SHOULDER HARNESS WAS USED, WAS IT: <input checked="" type="checkbox"/> LOCKED <input type="checkbox"/> UNLOCKED <input type="checkbox"/> TIGHT <input type="checkbox"/> BLACK <input type="checkbox"/> OTHER CONDITION		
NA	25. TYPE HELMET <b>Navy APH-5</b>	26. LIST PRESCRIBED MODIFICATIONS <b>Hardman Fittings BA CSEBS:13-57 Nape Straps; 19-59 Button &amp; Visor; Housing Assembly;</b>	
	27. OTHER MODIFICATIONS AND REASON FOR THEM <b>None</b>	28. DID HELMET FIT PROPERLY? IF NO, GIVE REASON <input type="checkbox"/> YES <input type="checkbox"/> NO	
PARACHUTE	29. HELMET FITTING WAS CONDUCTED BY: <input type="checkbox"/> WEARER <input type="checkbox"/> FLIGHT SURGEON <input checked="" type="checkbox"/> PARACHUTE RIGGER <input type="checkbox"/> AVIATION EQUIPMENT OFFICER <input type="checkbox"/> OTHER		
	30. TYPE CHUTE	31. LAST PACKING DATE	32. MODEL/TYPE BAILOUT OXYGEN
OTHER	33. AUTOMATIC RIPCORD, IF INSTALLED (Model and type) <input type="checkbox"/> NONE	34. DID AUTOMATIC RIPCORD FAIL? IF YES, WHY? <input type="checkbox"/> NO	
	35. IF MANUALLY ACTIVATED STATE REASON AND ANY DIFFICULTIES ENCOUNTERED	36. WAS RIPCORD ACTIVATION <input type="checkbox"/> MANUAL <input type="checkbox"/> AUTOMATIC	
37. DID CHUTE OPEN IMMEDIATELY? IF NO, GIVE REASON <input type="checkbox"/> YES <input type="checkbox"/> NO			38. ALTITUDE THAT CHUTE OPENED FEET
39. OPENING SHOCK WAS: <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE		40. BODY ATTITUDE AT OPENING	41. CONDITION OF CHUTE AFTER OPENING
42. CHUTE OSCILLATION PRESENT: <input type="checkbox"/> NONE <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE		43. IF OSCILLATION WAS PRESENT, HOW WAS IT STOPPED?	
44. WEATHER CONDITIONS DURING DESCENT (List in sequence)			45. TOPOGRAPHY OF LANDING SITE
46. WAS BAILOUT OXYGEN CONNECTED? <input type="checkbox"/> BEFORE EXIT <input type="checkbox"/> AFTER EXIT <input type="checkbox"/> NO <input type="checkbox"/> N.A.		47. WAS BAILOUT OXYGEN USED? IF NOT, WHY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
48. WHEN WAS IT ACTIVATED? <input type="checkbox"/> BEFORE EXIT <input type="checkbox"/> AFTER EXIT		49. GIVE DIFFICULTIES ENCOUNTERED WITH BAILOUT OXYGEN AND THEIR CAUSE, IF ANY	
50. WAS CHUTE HARNESS: <input type="checkbox"/> TIGHT <input type="checkbox"/> SNUG <input type="checkbox"/> LOOSE		51. WAS A SITTING POSITION IN SLING OBTAINED DURING DESCENT? IF NOT, WHY? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT ATTEMPTED	
52. SEAT CUSHION IF PROVIDED (Model/Type) <input type="checkbox"/> NONE		53. WAS PARASRAFT LANYARD CONNECTED TO LIFE VEST D RING? IF NOT, WHY? <input type="checkbox"/> NO <input type="checkbox"/> YES	
54. LIST TYPE OF PARACHUTE TRAINING COMPLETED BY THIS INDIVIDUAL <input type="checkbox"/> NONE			
55. IF ATTEMPT WAS MADE TO RELEASE PARASRAFT DURING DESCENT, WAS RELEASE ACTIVATED SUCCESSFULLY? <input type="checkbox"/> YES <input type="checkbox"/> NO		56. IF NO, GIVE REASON	
57. IF G-SUIT, EXPOSURE SUIT, FULL OR PARTIAL PRESSURE SUIT WAS WORN, DID IT FIT PROPERLY? IF NOT, LIST DISCREPANCIES IN FIT AND GIVE REASONS THEREFOR. <input type="checkbox"/> YES <input type="checkbox"/> NO			
58. WAS G-SUIT EQUIPPED WITH A SPRING-LOADED DISCONNECT ADAPTER? IF NO, GIVE REASON <input type="checkbox"/> YES <input type="checkbox"/> NO		59. LIST ALL ITEMS OF NON-STANDARD CLOTHING OR SURVIVAL EQUIPMENT UTILIZED <b>None</b>	
60. WAS ANY ITEM OF EQUIPMENT LOST? IF YES STATE ITEM, WHEN LOST, AND REASON FOR LOSS. <input type="checkbox"/> NO <input type="checkbox"/> YES		61. WAS ANY ITEM OF EQUIPMENT DISCARDED? IF YES, STATE ITEM, WHEN DISCARDED, AND REASON FOR DISCARD. <input type="checkbox"/> NO <input type="checkbox"/> YES	

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## SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE (Continued)

NAME OF INDIVIDUAL (Last, first, middle) <b>(b) (6)</b>		MODEL A/C <b>F-4B</b>	
RESTRAINT HARNESS	19. INTEGRATED HARNESS SYSTEM, MODEL/TYPE <b>Martin Baker 5</b>	20. INTEGRATED? <input checked="" type="checkbox"/> FULL <input type="checkbox"/> PARTIAL	21. MODIFICATIONS, IF ANY STATE REASON <b>None</b>
	22. DID INTEGRATED HARNESS FIT PROPERLY? IF NO, LIST DISCREPANCIES IN FIT AND GIVE REASONS THEREFOR <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		
HELMET	23. INTEGRATED HARNESS FITTING WAS CONDUCTED BY: <input checked="" type="checkbox"/> WEARER <input type="checkbox"/> FLIGHT SURGEON <input checked="" type="checkbox"/> PARACHUTE RIGGER <input type="checkbox"/> AVIATION EQUIPMENT OFFICER <input type="checkbox"/> OTHER		
	24. IF SHOULDER HARNESS WAS USED, WAS IT: <input checked="" type="checkbox"/> LOCKED <input type="checkbox"/> UNLOCKED <input type="checkbox"/> TIGHT <input type="checkbox"/> BLACK <input type="checkbox"/> OTHER CONDITION		
NA	25. TYPE HELMET <b>Navy APH-5</b>	26. LIST PRESCRIBED MODIFICATIONS <b>Hardman Fittings BA CSEBS:13-57 Nape Strap; 19-59 Button &amp; Visor; Housing Assembly;</b>	
	27. OTHER MODIFICATIONS AND REASON FOR THEM <b>None</b>	28. DID HELMET FIT PROPERLY? IF NO, GIVE REASON <input type="checkbox"/> YES <input type="checkbox"/> NO	
PARACHUTE	29. HELMET FITTING WAS CONDUCTED BY: <input type="checkbox"/> WEARER <input type="checkbox"/> FLIGHT SURGEON <input checked="" type="checkbox"/> PARACHUTE RIGGER <input type="checkbox"/> AVIATION EQUIPMENT OFFICER <input type="checkbox"/> OTHER		
	30. TYPE CHUTE	31. LAST PACKING DATE	32. MODEL/TYPE BAILOUT OXYGEN
33. AUTOMATIC RIPCORD, IF INSTALLED (Model and type) <input type="checkbox"/> NONE	34. DID AUTOMATIC RIPCORD FAIL? IF YES, WHY? <input type="checkbox"/> NO		
35. IF MANUALLY ACTIVATED STATE REASON AND ANY DIFFICULTIES ENCOUNTERED			36. WAS RIPCORD ACTIVATION <input type="checkbox"/> MANUAL <input type="checkbox"/> AUTOMATIC
37. DID CHUTE OPEN IMMEDIATELY? IF NO, GIVE REASON <input type="checkbox"/> YES <input type="checkbox"/> NO			38. ALTITUDE THAT CHUTE OPENED <b>FEET</b>
39. OPENING SHOCK WAS: <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE		40. BODY ATTITUDE AT OPENING	41. CONDITION OF CHUTE AFTER OPENING
42. CHUTE OSCILLATION PRESENT: <input type="checkbox"/> NONE <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE		43. IF OSCILLATION WAS PRESENT, HOW WAS IT STOPPED?	
44. WEATHER CONDITIONS DURING DESCENT (List in sequence)		45. TOPOGRAPHY OF LANDING SITE	
46. WAS BAILOUT OXYGEN CONNECTED? <input type="checkbox"/> BEFORE EXIT <input type="checkbox"/> AFTER EXIT <input type="checkbox"/> NO <input type="checkbox"/> N.A.		47. WAS BAILOUT OXYGEN USED? IF NOT, WHY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
48. WHEN WAS IT ACTIVATED? <input type="checkbox"/> BEFORE EXIT <input type="checkbox"/> AFTER EXIT		49. GIVE DIFFICULTIES ENCOUNTERED WITH BAILOUT OXYGEN AND THEIR CAUSE, IF ANY	
50. WAS CHUTE HARNESS: <input type="checkbox"/> TIGHT <input type="checkbox"/> SNUG <input type="checkbox"/> LOOSE		51. WAS A SITTING POSITION IN SLING OBTAINED DURING DESCENT? IF NOT, WHY? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT ATTEMPTED	
52. SEAT CUSHION IF PROVIDED (Model/Type) <input type="checkbox"/> NONE		53. WAS PARASRAFT LANYARD CONNECTED TO LIFE VEST D RING? IF NOT, WHY? <input type="checkbox"/> NO <input type="checkbox"/> YES	
54. LIST TYPE OF PARACHUTE TRAINING COMPLETED BY THIS INDIVIDUAL <input type="checkbox"/> NONE			
55. IF ATTEMPT WAS MADE TO RELEASE PARASRAFT DURING DESCENT, WAS RELEASE ACTIVATED SUCCESSFULLY? <input type="checkbox"/> YES <input type="checkbox"/> NO		56. IF NO, GIVE REASON	
57. IF G-SUIT, EXPOSURE SUIT, FULL OR PARTIAL PRESSURE SUIT WAS WORN, DID IT FIT PROPERLY? IF NOT, LIST DISCREPANCIES IN FIT AND GIVE REASONS THEREFOR. <input type="checkbox"/> YES <input type="checkbox"/> NO			
58. WAS G-SUIT EQUIPPED WITH A SPRING-LOADED DISCONNECT ADAPTER? IF NO, GIVE REASON <input type="checkbox"/> YES <input type="checkbox"/> NO		59. LIST ALL ITEMS OF NON-STANDARD CLOTHING OR SURVIVAL EQUIPMENT UTILIZED <b>None</b>	
60. WAS ANY ITEM OF EQUIPMENT LOST? IF YES STATE ITEM, WHEN LOST, AND REASON FOR LOSS. <input type="checkbox"/> NO <input type="checkbox"/> YES		61. WAS ANY ITEM OF EQUIPMENT DISCARDED? IF YES, STATE ITEM, WHEN DISCARDED, AND REASON FOR DISCARD. <input type="checkbox"/> NO <input type="checkbox"/> YES	

OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT — PAGE 6 OPHAV REPORT 3750.7  
FORM 3750-8E (REV. 5-58)

## SECTION 1 - PATHOLOGICAL FACTORS (Use A to denote ANTE MORTEM; P for POST MORTEM, when known and applicable.)

1. NAME OF INDIVIDUAL (Last, first, middle)

(b) (6)

MODEL A/C

F-4B

2. AGE <b>33</b>	3. HEIGHT <b>(b)</b> INCHES	4. WEIGHT <b>(b)</b> POUNDS	5. LOCATION AND DIRECTION FACING AT TIME OF ACCIDENT <b>Forward in cockpit</b>						6. INJURY CODE <b>B</b>																				
7. UNCONSCIOUSNESS <input type="checkbox"/> SHORT DURATION <input type="checkbox"/> LITTLE SIGNIFICANCE			8. INTERNAL INJURIES (Non-fatal cases)																										
HEAD INJURIES		9. CEREBRAL CONCUSSION <input type="checkbox"/> MINOR <input type="checkbox"/> SERIOUS <input type="checkbox"/> CRITICAL <input type="checkbox"/> FATAL						10. FACIAL INJURIES (N. E. C.)						11. INTRA-ORAL INJURIES															
		12. MINOR EYE INJURIES <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT						13. MAJOR EYE INJURIES <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT																					
SIMPLE																													
COMPOUND																													
COMMUNICATED																													
DIS- LOCATION		JAW						SHOULDER ELBOW WRIST						HIP KNEE ANKLE															
14. TYPE OF FRACTURE								SKULL		VERTEBRAE (Specify No.)				SHOUL- DER GIRDLE	RIBS	PELVIS	UPPER ARM		LOWER ARM		HAND		UPPER LEG		LOWER LEG		FOOT		
CRAN.	FACIAL	CERV.	HORN.	LUMBAR	SACRAL	COCCYX		R	L	R	L	R	L				R	L	R	L	R	L	R	L					
15. AMPUTATIONS/AVULSIONS (State Parts)								16. LIST PRE-EXISTING PHYSICAL DEFECTS PRESENT AT TIME OF POST CRASH EXAMINATION																					

17. SOFT TISSUE INJURIES		LACERATIONS			CONTUSIONS/SPRAIN/STRAIN			ABRASIONS			18. <input type="checkbox"/> DROWNS		
		MILD	MODERATE	SEVERE	MILD	MODERATE	SEVERE	MILD	MODERATE	SEVERE			
HEAD (N. E. C.)	VENTRAL												
	DORSAL												
NECK													
THORAX	VENTRAL												
	DORSAL												
ABDOMEN	VENTRAL												
	DORSAL												
EXTREMITIES	UPPER												
	LOWER												
19. BURNS	DEGREE	1ST	2ND	3RD	1ST	2ND	3RD	1ST	2ND	3RD		20. EXTENT OF CARBONIZATION: <input type="checkbox"/> NONE <input type="checkbox"/> COMPLETE ARE TISSUE SPECIMENS OBTAINABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
20. FROST BITE	AREA	HEAD(Ventral)	Dorsal	TRUNK(Ventral)	Dorsal	ARMS	LEGS						

NOTE: Attach a detailed narrative account of injuries, cause, structures causing injury, magnitudes of force, and include whether ANTE-OR POST-MORTEM if determined. It is necessary to give as clear a picture of injury cause and sequence as possible.

24. ADMITTED TO SICK LIST IF YES, GIVE DIAGNOSIS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. DIAGNOSIS NO. (WAXMED P-1294)				26. ESTIMATED STAY ON SICK LIST DAYS			
27. GROUNDED IF YES GIVE REASON <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								28. ESTIMATED DURATION DAYS			

29. PRIMARY CAUSE OF DEATH (Use Basic Diagnostic Nomenclature, WAXMED P-1294) 30. SECONDARY CAUSE OF DEATH  
RE: \_\_\_\_\_

31. AUTOPSY PERFORMED: <input type="checkbox"/> YES <input type="checkbox"/> NO		32. PROTOCOL <input type="checkbox"/> ATTACHED <input type="checkbox"/> WILL BE FORWARDED		33. AUTOPSY CONDUCTED BY <input type="checkbox"/> PATHOLOGIST <input type="checkbox"/> FLIGHT SURGEON		34. IF FLIGHT SURGEON DOES AUTOPSY USE "AUTOPSY GUIDE FOR A/C ACCIDENT FATALITIES", AFM, 1967.					
35. SPECIMEN		TEST PERFORMED		RESULTS		SPECIMEN		TEST PERFORMED		RESULTS	
BLOOD:		I				TISSUES (ONE)					
		2		Q		MUSCLE					
		3				VISCERA					
URINE						OTHER					
B-I CONTENTS											

36. IF ULTRAVIOLET LIGHT OR OTHER SPECIALIZED PROCEDURES WERE USED AT THE MISHAP SITE OR AUTOPSY, LIST THEM IN THIS SPACE. FOR EACH ENTRY IN THIS SPACE A NARRATIVE ACCOUNT OF THEIR RESULTS AND INTERPRETATION WILL BE ATTACHED.